

# NEVADA UNIFORM PRIOR AUTHORIZATION FORM



## For Behavioral Providers

To file electronically, providers in Nevada must register for access to the online prior authorization tool:

To file via facsimile send to:  
866.217.6837

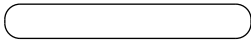
To initiate registration, send an email to [PMAC@Cigna.com](mailto:PMAC@Cigna.com) and include the following information:

- **Provider or facility name**
- **Mailing address**
- **Email address**
- **Contact name**
- **Contact telephone number**

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PRIOR AUTHORIZATION AND REFERRAL FORM



Health Plan of Nevada (HPN): <input type="checkbox"/> Nevada Exchange: <input type="checkbox"/> Sierra Choice: <input type="checkbox"/> Tier I (HMO) <input type="checkbox"/> Tier II (PPO) <input type="checkbox"/> Tier III Senior Dimensions: <input type="checkbox"/> Smart Choice/Nevada Check Up: <input type="checkbox"/> Sierra Health and Life: <input type="checkbox"/> Out of plan <input type="checkbox"/> Sierra Spectrum: <input type="checkbox"/>	Primary Care Provider Name / Address / Phone & Fax #:		
Phone: (LV) 702-242-7330 (outside LV) 800-288-2264 Fax #: (LV) 702838-8297 (outside LV) 888-633-9301	Requesting Provider Name:		
<b>Date of Request:</b>			
Member Name & member number:	Requesting Provider's Address & Phone #:  <b>Requesting Provider's Fax #:</b>		
Members Address & Phone #:	Requesting Provider's Tax ID #:  HIPAA Provider Identification #:		
Member's DOB:	Contact Person (Name, Phone & Fax # : )		
Employer Group's Name & Phone #:	Requesting Provider's Signature or Stamped Signature		
Other Insurance(s):	_____		
<b>Diagnosis (incl. ICD code):</b>			
Procedure/Treatment Request (incl. CPT code):	Number of Treatments Requested: _____		
Inpatient / Outpatient: Services Requested by Patient: <input type="checkbox"/> YES <input type="checkbox"/> NO			
Service Provider / Address / Phone #:	Place of Service / Facility and Address:  Requested Procedure Date / Start Treatment Date:		
Area for internal health plan use only	Authorization:	Date of Authorization:	Pended / Denied: (Reason):
Health Plan Contact name & phone #:	Yes <input type="checkbox"/> No <input type="checkbox"/>	Authorization Number:	
<b><i>Pertinent Attachments=Information to support the proposed diagnosis, treatment/procedure; i.e. current clinical findings (progress reports), results of laboratory testing, imaging studies (x-rays, etc.) must be submitted to prevent processing delays.</i></b>			

**\* All Sections of this form must be completed.**

**\*\*On adverse determinations a reconsideration / expedited appeal may be requested**

This referral/authorization is not a guarantee of payment. Payment is contingent upon eligibility, benefits available at the time the service is rendered, contractual terms, limitations, exclusions, and coordination of benefits, and other terms & conditions set forth in the member's Evidence of Coverage, Certificate of Coverage, or Self Insured Employer's Plan Documents.

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