UnitedHealthcare®

Illinois Certification of Medical Necessity Form

For Continued Use of Medication to be uptiered or excluded

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:
Medication Information (required)					
Medication Name:			Strength:		Dosage Form:
Original start date for Medication:			Same Strength and Dosage? Yes or No		
Prescriber Attestation:					
The prescriber certifies that the medication and strength stated above for this member is medically necessary for their continued treatment. Prescriber's signature: _____ Date: _____					

Please send this form to the address below:

OptumRx

Prior Authorization Department
P.O. Box 25182

Santa Ana, CA 92799

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