Health Plan of Nevada
A UnitedHealthcare Company

Sierra Health and Life®
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United Healthcare

	STANDARD		EXPEDITE

Medical Necessity Request Form

[Applicable for HPN/SHL Commercial/Medicaid members only]

Member Name:____ **Date of Request** ________________

Primary Cardholder ID #:______________________________ **M / F** **DOB:** ____________________

Documented Allergies: ____

Physician Information - COMPLETE INFORMATION IS REQUIRED TO RECEIVE RESPONSE

Physician Name (please print clearly): ____

Physician Signature:________________________________ **DEA No.:** ____________________

Phone:________________________________ **FAX:** ____________________________

Address: ____

Office Contact Person ____

Requested Medication

Drug name, strength, quantity: ____

Directions: ____

One drug request per form please

Additional Information: The following information <u>must be included</u> or request will be returned. (Please, when available, attach copies of office notes documenting prior therapy, diagnosis, lab results, etc.)

Diagnosis:

____

Medication History for this Diagnosis:

Drug	Daily Dose	Started	Stopped	Reason for discontinuing medication:
		/	/	
		/	/	
		/	/	

Clinical Rationale/Supporting Documentation: Why do you feel this drug is superior to current Preferred Drug(s)? (Include documented efficacy in this patient, documented failure or allergy of preferred meds, etc.)

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PHONE: (702) 242-7050, Option #6
(800) 443-8197, Option #6
FAX: (702) 242-6751
(800) 997-9672

OR Mail to:
HPN/SHL - PHARMACY SERVICES
Attn: Medical Necessity
P.O. Box 15645
Las Vegas, NV 89114-5645