NEVADA UNIFORM PRIOR AUTHORIZATION FORM

EVERNORTH℠

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 and include the following information:

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

CLEAR FORM

NEVADA UNIVERSAL

PRIOR AUTHORIZATION AND REFERRAL FORM

Health Plan of Nevada (HPN): ☐ **Nevada Exchange:** ☐ **Sierra Choice:** ☐ **Tier I (HMO)** ☐ **Tier II (PPO)** ☐ **Tier III** **Senior Dimensions:** ☐ **Smart Choice/Nevada Check Up:** ☐ **Sierra Health and Life:** ☐ **Out of plan** ☐ **Sierra Spectrum:** ☐	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:
Date of Request:	
Member Name & member number:	Requesting Provider's Address & Phone #: **Requesting Provider's Fax #:**
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):	
Diagnosis (incl. ICD code):	Procedure/Treatment Request (incl. CPT code): Number of Treatments Requested: _____ Inpatient / Outpatient: Services Requested by Patient: ☐ *YES* ☐ *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 ☐	No ☐	Authorization Number:	

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.*

**** 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.

CLICK TO PRINT

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