Medicare Advantage Plans – Prior Authorization Request Form

Fax completed form to: 1-608-252-0840

Choose Type of Service:

Durable Medical Equipment	**Skilled Nursing Facility**	**Outpatient**	**Medical Drug Injectable**	**Elective Admissions includes Acute Rehab & LTAC**

Choose One:

Standard Request - Determination will be made within 14 calendar days after receipt of the request

Expedited Request - Waiting for a decision risks the member's life, health or pain that cannot otherwise be managed

Emergency Admission Notification – Emergency services do not require prior authorization

PATIENT DEMOGRAPHICS

Patient Name:		Date of Birth:
Member ID:		Phone Number:
Street Address:		
City:	State:	ZIP Code:

REFERRING PROVIDER INFORMATION

Provider Name:	Provider #:	Specialty:	Phone #:
Street Address:			Fax #:
City:	State:		ZIP Code:
Provider #:	Specialty:		

REFERRED TO PHYSICIAN/FACILITY/PROVIDER INFORMATION

Referred To:	Specialty:	Phone #
Street Address:		Fax #
City:	State:	ZIP Code:

REQUEST INFORMATION

Date (s) of Service:	Number of Visits:
CPT Code(s):	Diagnosis Code(s):

Durable Medical Equipment Description	HCPCS	Quantity	Rental or Purchase

Skilled Nursing Facility
Member Admitted From:
Number of Medicare SNF days utilized during this benefit year:

Medical Drug Injectable	HCPCS	Dosage	Frequency	Place of Service	Expected Length of Therapy

Required Explanation Provide in Additional Information below

Alternate drug(s) contraindicated or previously tried, but with adverse outcome (e.g. toxicity, allergy, or therapeutic failure) – Supply documentation for (1) Drug(s) contraindicated or tried; (2) adverse outcome for each; (3) if therapeutic failure, length of therapy on each drug(s)

Complex patient with one or more chronic conditions (for example, psychiatric condition, diabetes) is stable on current drug(s) – Include anticipated significant adverse clinical outcome

Other:

Additional Information:

Form Submitted By:	Phone:	Fax:

Fax form to: **1-608-252-0840** or Mail to: The Health Plan, Attn: Utilization Management, PO Box 56099, Madison, WI 53705-9399. **Include any clinical or office notes that would support this request.** Requests to non-plan providers must be approved prior to obtaining services.