CARE WISCONSIN®

Inpatient Admission Authorization Request

For Urgent or Emergent Admissions:

Please notify Care Wisconsin within 1 business day of an admission.

Please provide the following clinical information to support medical necessity of all requests and fill form completely. Attach another sheet if necessary.

- H&P
- Discharge Summary
- MD Progress Notes
- Labs/Radiology Studies

Member Name:	D.O.B.:	Medicaid ID #:
Member Phone:	Member address:	
Requesting Provider Name/Clinic:		Tax ID:
Address:		
Clinical Contact/Title:	Phone:	Fax:
Facility Name:		Tax ID:
Address:		
Facility Utilization Review Dept./ Clinical Contact/Title:	Phone Number:	Fax:
Facility Medical Records Dept. Phone Number:		Fax:

Type of Request: ◉ Elective ○ Urgent ○ Emergent

○ Retrospective (only within 14 business days from urgent/emergent admission

Discharge Date (required for retrospective reviews): / / 2018

Please send us the H&P and discharge summary to ensure prompt determination.

Date of admission: / / 2019	Time of admission:	Admission Source: Please select one
Admitting ICD10 Code:	Admitting ICD10 Code:	Other:
Admitting ICD10 Code:	Requested length of stay:	

Type of bed:

☐ ICU/CCU	☐ Observation	☐ Hospice	
☐ Intermediate/Stepdown	☐ OB	☐ Rehab	☐ Court-ordered Inpatient Stay
☐ Medical/Surgical	☐ Swing bed	☐ Mental Health	

Privacy and Confidentiality:
The information within this fax message is intended for the recipient(s) only. If you have received this fax in error, please contact us at 1-800-963-0035 (phone) or 608-210-4050 (fax) and destroy this document received. State and Federal Law prohibits any unauthorized use of this information. Thank you for your cooperation.

No Guarantee of Payment

A prior authorization or precertification does not imply or guarantee payment, nor is it a verification of a member's eligibility at the point of service. Payments of benefits are subject to all terms, conditions, limitations, and exclusions of the program's contract and eligibility of the member at the time services are rendered.