CARE WISCONSIN

Outpatient Therapy/Cardiac/Pulmonary Rehab Prior Authorization Request

For prompt and accurate determination, please fax this completed form to 608-210-4050. Please provide clinical information to support medical necessity of all requests and fill form completely. Attach another sheet if necessary.

Member Name:	**D.O.B.:**	**Medicaid ID:**
#:Member Phone:	**Member address:**	
Requesting Provider Name/Clinic:		**Tax ID:**
Address:		
Clinical Contact/Title:	**Phone Number:**	**Fax Number:**
Servicing Provider Name/Clinic:		**Tax ID:**
Address:		
Clinical Contact/Title:	**Phone Number:**	**Fax Number:**

Request Type? ◯ **Standard** ◯ **Expedited: Please explain rationale for urgency:**
Expedited is defined as: Care and services that the physician indicates or the HMO determines that following the ordinary time frame could jeopardize the member's health or ability to regain maximum function.

Diagnosis or symptom description: **ICD-10:**

The first eight visits do not require prior authorization. For initial request after 8th visit, send evaluation, summary, and progress notes.

Date 8th visit scheduled or occurred:

Type of therapy service requested:

☐ PT	Total # visits:	Frequency/wk:	Duration:
☐ OT	Total # visits:	Frequency/wk:	Duration:
☐ ST	Total # visits:	Frequency/wk:	Duration:
☐ Cardiac Rehab	Total # visits: CPT code:	Frequency/wk:	Duration:
☐ Pulmonary (Partnership only)	Total # visits: CPT code:	Frequency/wk:	Duration:

Privacy and Confidentiality:

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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.