CARE WISCONSIN

Procedure and Imaging 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.

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:**

CPT/HCPC code requested:	**Description:**	**Quantity:**
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Please select one:

☐ **Anticipate Outpatient service only.**

☐ **Anticipate Observation stay for _____ hours.**

☐ **Anticipate Inpatient Admission for _____ days. Anticipated Date of Admission:**

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.

1617 Sherman Avenue**, Madison, WI 53704 • Phone: 800-963-0035 • TTY: WI Relay 711 • Fax: 608-210-4050**