Clear Form

GENERAL PRIOR AUTHORIZATION REQUEST FORM

FYI: Review our provider manual criteria references. Submit documentation to support medical necessity along with this request. Failure to provide required documentation may result in denial of the request.

Fax form and relevant clinical documentation to:
715-787-7316

For questions, call:
715-631-7412 or 1-855-931-4851

PATIENT INFORMATION:		
Name:		
Member ID:	PMI:	
Address:		
City:	State:	Zip Code:
Date of Birth:	Phone:	

ORDERING PRACTITIONER INFORMATION:		
Practitioner Name:	ID/ NPI Number:	
Address:		
City:	State:	Zip Code:
Phone:	Fax:	

SERVICING PRACTITIONER INFORMATION:		
Servicing Practitioner Name:		
Servicing Practitioner Clinic Location Name*:		
Clinic Location NPI Number (required)*:		
Clinic Location Address:		
City:	State:	Zip Code:

CONTACT PERSON FOR PRIOR AUTHORIZATION QUESTIONS:	
Name:	
Phone:	Fax:
Email:	

REASON FOR PRIOR AUTHORIZATION REQUEST: (SELECT ONE)
☐ UCare Prior Authorization Requirement
☐ Benefit Exception
☐ Network Exception
☐ Experimental/ Investigational

PROCEDURE CODE(S) HCPCS OR CPT:			
Description of Request:			

ICD-10 DIAGNOSIS CODE(S):			
Diagnosis description (include all) relevant to this request:			

SERVICE/ ITEM REQUESTED:
Number of Units/ Visits Requested:
Frequency (if applicable):
Start Date Requested (required):
End Date Requested:

☐ STANDARD REQUEST:	☐ EXPEDITED REQUEST:
➢ Medicare and Medicaid decision within 10 business days. ➢ IFP decision within 5 business days.	➢ Only request an urgent/ emergent review if waiting the standard review timeframe would potentially jeopardize the member's health, life, or ability to regain function. ➢ Medicare and Medicaid decision within 72 hours. ➢ IFP decision within 48 hours including 1 business day. ➢ Billing and retrospective authorizations are not expedited.
1. Proposed date of service:	
2. Will waiting the standard review time seriously jeopardize member's health, life or ability to regain maximum function? ☐ Yes ☐ No	
3. Clinical reason for urgency (unrelated to scheduling issues):	
4. Physician Signature:	

CONFIRM AND COMPLETE THE REQUIRED STEPS TO PROCEED:	
☐	Clinical notes supporting any of the above have been included in the submission form. (Incomplete forms will be returned and can delay decision time)

Notes:

Do not use this form for Injectable Drug Authorization Request, DME Authorization, Home Care Services, Medicare Pre-Determination, or Mental Health and Substance Use Disorder Services.

Please allow 14 calendar days for decision. Submission of all relevant clinical information with the request will reduce the number of days for the decision.