OUTPATIENT MEDICAID PRIOR AUTHORIZATION FORM

mhs health wisconsin

Complete and **Fax**: 866-467-1316
Transplant: **Fax** 833-769-1051
Behavioral Health Requests: **Fax** 833-522-2807

☐ Request for additional units. Existing Authorization ______ Units ______

☐ **Standard Request -** Determination within 5 working days of receiving all necessary information, not to exceed 14 calendar days from receipt.

☐ **Urgent Request -** I certify this request is urgent and medically necessary to treat an injury, illness or condition (not life threatening) within 72 hours to avoid complications and unnecessary suffering or severe pain.

URGENT REQUESTS MUST BE SIGNED BY THE REQUESTING PHYSICIAN TO RECEIVE PRIORITY.

*** INDICATES REQUIRED FIELD**

MEMBER INFORMATION

*Date of Birth ______ (MMDDYYYY)

*Member ID ______

Last Name, First ______

ORDERING PROVIDER INFORMATION

*Ordering NPI ______

*Ordering TIN ______

Ordering Provider Contact Name ______

Ordering Provider Name ______

Phone ______

*Fax ______

SERVICING PROVIDER / FACILITY INFORMATION

☐ Same as Ordering Provider

*Servicing NPI ______

*Servicing TIN ______

Servicing Provider Contact Name ______

Servicing Provider/Facility Name ______

Phone ______

Fax ______

AUTHORIZATION REQUEST

***Primary** Procedure Code ______ (CPT/HCPCS) ______ (Modifier)

Additional Procedure Code ______ (CPT/HCPCS) ______ (Modifier)

Start Date *OR Admission Date ______ (MMDDYYYY)

*Diagnosis Code ______ (ICD-10)

Additional Procedure Code ______ (CPT/HCPCS) ______ (Modifier)

Additional Procedure Code ______ (CPT/HCPCS) ______ (Modifier)

End Date *OR* Discharge Date ______ (MMDDYYYY)

Total Units/Visits/Days ______

*OUTPATIENT SERVICE TYPE

(Enter the Service type number in the box) ______

Behavioral Health
510 BH Medical Management
512 BH Community Based Services
513 BH Crisis Psychotherapy
514 BH Day Treatment
515 BH Electroconvulsive Therapy
516 BH Intensive Outpatient Therapy
519 BH Outpatient Therapy
520 BH Professional Fees
521 BH Psychological Testing
522 BH Psychiatric Evaluation

422 Biopharmacy
299 Drug Testing
709 Genetic Testing & Counseling
249 Home health
390 Hospice Services
141 Imaging
997 Office Visit/Consult
794 Outpatient Services
171 Outpatient Surgery
202 Pain Management
470 Personal Care Worker Services
101 Physical Therapy
790 Occupational Therapy
701 Speech Therapy

107 Respite Care
201 Sleep Study
993 Transplant Evaluation
209 Transplant Surgery
724 Transportation

DME
417 Rental
120 Purchase ______ (Purchase Price)

ALL REQUIRED FIELDS MUST BE FILLED IN AS INCOMPLETE FORMS WILL BE REJECTED.
COPIES OF ALL SUPPORTING CLINICAL INFORMATION ARE REQUIRED. LACK OF CLINICAL INFORMATION MAY RESULT IN DELAYED DETERMINATION.

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

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