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
Biopharmacy: **Fax** 833-893-1519

☐ Request for additional units. Existing Authorization ☐☐☐☐☐☐☐☐☐☐☐☐ Units ☐☐☐☐

☐ **Standard Request -** Determination within 5 working days of receiving all necessary information, not to exceed 7 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

*Member ID

*Date of Birth (MMDDYYYY)

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 Intenstive 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.

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