



MEDICARE OUTPATIENT AUTHORIZATION WISCONSIN

All Part B Drug Requests: **Fax** 844-960-1787
Expedited Requests Non-Duals: **Call** 800-977-7522
Expedited Requests Duals: **Call** 1-855-455-3572
Standard Requests: **Fax** 877-687-1183
Transplant Requests: **Fax** 833-783-0879
Behavioral Health Requests: **Fax** 833-325-1832

Request for additional units. Existing Authorization

Units

☐ **For Standard (elective Admission) requests, complete this form and FAX to the appropriate department.** Determination made as expeditiously as the enrollee's health condition requires, but no later than **7** calendar days after receipt of request.

☐ **For Expedited requests, Non Duals please Call 800-977-7522 and Duals Call 1-855-455-3572.** Expedited requests are made when the enrollee or his/her physician believes that waiting for a decision under the standard timeframe could place the enrollee's life, health, or ability to regain maximum function in serious jeopardy.

* INDICATES REQUIRED FIELD

MEMBER INFORMATION

Member ID *

Last Name, First

Date of Birth *

(MMDDYYYY)

REQUESTING PROVIDER INFORMATION

Requesting NPI *

Requesting TIN *

Requesting Provider Contact Name

Requesting Provider Name

Phone

Fax *

SERVICING PROVIDER / FACILITY INFORMATION



Same as Requesting 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 boxes)

422 Biopharmacy (Please Fax To 844-960-1787)
712 Cochlear Implants and Surgery
299 Drug Testing
922 Experimental & Investigational Services
205 Genetic Testing and Counseling
249 Home Health
290 Hyperbaric Oxygen Therapy
141 Imaging Services
395 Infertility Diagnosis or Treatment
729 Neuropsychological Testing
410 Observation
997 Office Visit/Consult
794 Outpatient Services
171 Outpatient Surgery

202 Pain Management
650 Radiation Therapy
201 Sleep Study
993 Transplant Evaluation
209 Transplant Surgery
212 Therapy Evaluation

Therapy

790 Occupational
101 Physical
701 Speech

Behavioral Health

528 BH Chemical Substance Abuse
529 BH Psychiatric Admission
531 BH Eating Disorder
510 BH Medical management
530 BH PHP
512 BH Community Based Services
513 BH Crisis Psychotherapy
514 BH Day Treatment
515 BH Electroconvulsive Therapy
516 BH Intensive Outpatient Therapy (IOP)
518 BH Mental Health/Chemical Dependency Observation
522 BH Psychological Evaluation
519 BH Outpatient Therapy
520 BH Professional Fees
521 BH Psychological Testing

Outpatient Services Example:
-Skin Debridement/wound care

Home Health Example:
-Skilled Nursing Visits
Are services needed for discharge planning?

☐ Yes ☐ NO

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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