mhs health wisconsin

MEDICAID

PRIOR AUTHORIZATION/REFERRAL FAX FORM

Complete and Fax to: (866) 467-1316

☐ 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.

X ____

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

*** INDICATES REQUIRED FIELD**

MEMBER INFORMATION

Member Phone Number ____

Date of Birth * ____ (MMDDYYYY)

Member ID/Medicaid ID * ____

Last Name, First ____

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
401 Cardiac Pulmonary Rehab
771 Dialysis

DME
417 Rental
120 Purchase $ ____ (Purchase Price)

299 Drug Testing
709 Genetic Testing
249 Home Health

141 Imaging Services
211 OB Ultrasound(s)
790 Occupational Therapy
497 Office Visit/Specialty Consult
927 Outpatient Hospice
794 Outpatient Services

Pain Management
429 Office Visit
170 Other Site

470 Personal Care Worker Services
101 Physical Therapy
325 Podiatry Office Visit
201 Sleep Study
701 Speech Therapy

Surgery
400 Inpatient
427 Outpatient

724 Transportation

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.

For Medicare Prior Authorization Requests-Please fax to 877-687-1183.