INDEPENDENT CARE HEALTH PLAN

Prior Authorization Request Form

***Receipt of an approved prior authorization does not guarantee coverage or payment by iCare**. Benefits are determined based on the dates that the services are rendered. Please fill out this form completely and fax to **(414) 231-1026**. An incomplete form may delay processing and/or claims payment.*

Member Information			
Plan:	□ ***i*Care Medicare**	□ ***i*Care Medicaid**	□ ***i*Care BadgerCare-Plus**

Member Name:		**DOB:**	
Member ID#:		**Phone:**	
Service Type:	□ Elective/Routine (14-day turnaround time)	□ Expedited/Urgent* (72-hr. turnaround time)	

Definition of Urgent/Expedited:** when the treatment requested is required to prevent imminent, serious deterioration in the member's health or threatens to jeopardize the member's ability to regain maximum function. ***iCare reserves the right to deny the request for urgent review for all requests outside of this definition.

Requesting/Servicing Provider Information			
Provider/Supplier Name:		NPI:	
Contact at Provider or Supplier's Office:	Name:	Phone:	Fax:

Clinical Notes and Supporting Documentation is Required to Review for Medical Necessity

Referral/Service Type Requested			
Inpatient □ Surgical Procedures □ SNF □ LTAC □ IRF	**Outpatient** □ Surgical Procedure □ Diagnostic Procedure □ PT* □ OT* □ ST* **Date of initial eval: _____* □ Referral	□ PCW □ Home Health □ DME □ In Office □ Other	**Behavioral Health** □ Partial Hospitalization □ Intensive Outpatient Therapy □ Community Day Treatment □ Crisis Stabilization/Diversion □ In Home Psychotherapy □ Psychological Testing >4 hours

ICD 10 Diagnosis Code & Description:					
CPT/HCPC:	Code	Description	# of Units, hrs/days	□ Rental □ Purchase	
Number of Visits Requested:		DOS:	From:	To:	
Comments:					

INDEPENDENT CARE HEALTH PLAN
1555 N. RiverCenter Dr. Suite 206
Milwaukee, WI 53212
Tel 414-223-4847 Fax 414-231-1026
www.icare-wi.org