



Outpatient Prior Authorization Request Form

Please fill out this form completely and fax to **414-231-1026**
 For PA Status call Customer Service at **414-223-4847**
 iCare Prior Authorization Department 414-299-5539 or 855-839-1032

Member Information			
Member Name:		DOB:	
Member ID#:		Phone:	
Service Type:	<input type="checkbox"/> Court Ordered Service (72-hr. turnaround time)	<input type="checkbox"/> Clinical Trial (72-hr. turnaround time)	
	<input type="checkbox"/> Elective/Routine (14-day turnaround time)	<input type="checkbox"/> 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.

Servicing Provider Information (facility/supplier who will perform service/procedure)			
Provider/ Supplier Name:		NPI:	
Contact at Provider/Supplier:	Tax ID Number:	Phone:	
Address:		Fax:	
Contact Email:			

Ordering Practitioner Information (practitioner who ordered service/procedure)			
Practitioner Name:		NPI:	
Contact Name:	Tax ID Number:	Phone:	
Address:		Fax:	

Referral/Service Requested		
Outpatient Therapy <input type="checkbox"/> PT* <input type="checkbox"/> OT* <input type="checkbox"/> ST* <input type="checkbox"/> Cardiac Rehab* <input type="checkbox"/> Pulmonary Rehab* <i>*Date of initial eval: _____</i>	<input type="checkbox"/> Procedure <input type="checkbox"/> Home Health/Hospice <input type="checkbox"/> Referral or Second Opinion <input type="checkbox"/> Urine Drug Screen <input type="checkbox"/> Health Check "Other Services" <input type="checkbox"/> Specialty Medication	DME/DMS <input type="checkbox"/> New Rental <input type="checkbox"/> Continued Rental Original delivery date _____ <input type="checkbox"/> Purchase <input type="checkbox"/> Replacement <input type="checkbox"/> DMS Overage

Continuity/Transition of Care request: <input type="checkbox"/>	<i>Please check if this request is for an active course of treatment previously approved by another insurance carrier/Medicare HMO?</i>
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ICD 10 Diagnosis Code	CPT/HCPCS Code	Description	# of Units, hours, or days

Date of Service	From:	To:	Number of Visits:
Date Extension of previously approved services?	YES	<input type="checkbox"/>	If yes, requested end date:

Comments (please do not mark level of urgency here, see top of form):

Clinical Notes, Supporting Documentation, and Physician Order are Required to Review for Medical Necessity

*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.
 An incomplete form may delay processing and/or claims payment*