Inpatient Prior Authorization Request Form

Independent Care Health Plan (iCare) must be notified of all inpatient stays ***within one (1) business*** *day of the admission.*

Please fill out this form completely and fax to (414) 231-1075
For PA Status call Customer Service at 414-223-4847
iCare Prior Authorization Department 414-299-5539 or 855-839-1032

Member Information			
Line of Business:	□ ***i*Care Medicare**	□ ***i*Care Medicaid**	□ ***i*Care BadgerCare Plus**
Member Name:		**DOB:**	
Member ID#:		**Phone:**	

Admitting Facility Information	
Request Type: □ **Inpatient Medical** □ Initial Request □ Extension □ Retrospective □ Transfer from another facility □ **Observation** □ **Maternity/OB Notification** *(include baby stats)*	**Behavioral Health:** □ **Voluntary** □ **Emergency/Involuntary** □ **Court Ordered Service** Court Date: _____ □ **Forensic Admission** □ **PHP/IOP**: □ H2019 □ H2012

Admission Date:		**Admission Time:**	
ICD-10 Diagnosis & Description:			
Admitting MD:			
Facility Name:		**Facility NPI:**	
Facility Address:			

Facility Contact			
Name:		**Title:**	
Phone:		**Fax:**	
Email:			

Receipt of an approved authorization does not guarantee coverage or payment by *i*Care.
Benefits are determined based on the dates that the services are rendered.
An incomplete form may delay processing and/or claims payment.

INDEPENDENT CAREHEALTH PLAN
1555 N RiverCenter Dr. Suite 206 Milwaukee, WI 53212
www.iCareHealthPlan.org

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