



## 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			
<b>Plan:</b>	<input type="checkbox"/> iCare Medicare	<input type="checkbox"/> iCare Medicaid	<input type="checkbox"/> iCare BadgerCare-Plus
<b>Member Name:</b>		<b>DOB:</b>	
<b>Member ID#:</b>		<b>Phone:</b>	
<b>Service Type:</b>	<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.**

Requesting/Service Provider Information			
<b>Provider/Supplier Name:</b>			<b>NPI:</b>
<b>Contact at Provider or Supplier's Office:</b>	<b>Name:</b>	<b>Phone:</b>	<b>Fax:</b>

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

Referral/Service Type Requested				
<b>Outpatient Therapy</b> <input type="checkbox"/> PT* <input type="checkbox"/> OT* <input type="checkbox"/> ST* <input type="checkbox"/> Cardiac Rehab* <input type="checkbox"/> Pulmonary Rehab*  <b>*Date of initial eval:</b> ____	<input type="checkbox"/> Surgical Procedure <input type="checkbox"/> Diagnostic Procedure <input type="checkbox"/> In Office <input type="checkbox"/> Referral or Second Opinion <input type="checkbox"/> Elective Inpt. Procedure <input type="checkbox"/> Urine Drug Screen	<input type="checkbox"/> Psychological or Neuropsychological Testing >4 hours <input type="checkbox"/> DME <input type="checkbox"/> Home Health/Hospice <input type="checkbox"/> Personal Care Worker (PCW) <input type="checkbox"/> Other		
<b>ICD 10 Diagnosis Code &amp; Description:</b>				
<b>CPT/HCPC:</b>	<b>Code</b>	<b>Description</b>	<b># of Units, hrs/days</b>	<b>DME Please Select One:</b>
				<input type="checkbox"/> New Rental
				<input type="checkbox"/> Continued Rental
				<input type="checkbox"/> Purchase
			<input type="checkbox"/> Replacement	
<b>Date of Service</b>	<b>From:</b>	<b>To:</b>	<b>Number of Visits:</b>	
<b>Comments:</b>				

**INDEPENDENT CARE HEALTH PLAN**

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