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

| **Referral/Service Type Requested** | | |
|---|---|---|
| **Outpatient Therapy**<br>□ PT* □ OT* □ ST*<br>□ Cardiac Rehab*<br>□ Pulmonary Rehab*<br><br>***Date of initial eval: ____** | □ Surgical Procedure<br>□ Diagnostic Procedure<br>□ In Office<br>□ Referral or Second Opinion<br>□ Elective Inpt. Procedure<br>□ Urine Drug Screen | □ Psychological or Neuropsychological Testing >4 hours<br>□ DME<br>□ Home Health/Hospice<br>□ Personal Care Worker (PCW)<br>□ Other |
| ICD 10 Diagnosis Code & Description: | | |

| CPT/HCPC: | Code | Description | # of Units, hrs/days | **DME Please Select One:** |
|---|---|---|---|---|
| | | | | □ New Rental<br>□ Continued Rental<br>□ Purchase<br>□ Replacement |
| | | | | |
| | | | | |
| | | | | |

| Date of Service | From: | To: | Number of Visits: |
|---|---|---|---|

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*