# General Prior Authorization Form

**Fax completed form to: 608-252-0830**

| PATIENT DEMOGRAPHICS | | | |
|---|---|---|---|
| Patient Name: | | | Date of Birth: |
| Member ID: | | | Phone Number: |
| Street Address: | | | |
| City: | State: | | Zip Code: |

| REFERRING PROVIDER INFORMATION | | | |
|---|---|---|---|
| Provider Name: | | | Phone #: |
| Street Address: | | | Fax #: |
| City: | State: | | Zip Code: |
| Provider #: | Tax ID #: | NPI: | Specialty: |

| REFERRED TO PHYSICIAN/FACILITY/PROVIDER INFORMATION | | | |
|---|---|---|---|
| Referred To: | | | Phone # |
| Street Address: | | | Fax # |
| City: | State: | | Zip Code: |
| Provider #: | Tax ID #: | NPI: | Specialty: |

| REQUEST INFORMATION | | |
|---|---|---|
| Date (s) of Service: | Diagnosis Code(s): | ICD Code(s): |
| CPT Codes and Description: | | |
| # of Visits | 3rd party liability: ☐ W/C ☐ MVA ☐ Other | |

**Additional Information:**

| Form Submitted By: | | |
|---|---|---|
| Name: | Phone: | Fax: |

The completed form can be faxed to: 608-252-0830.
If you have any questions regarding the services or form, please contact please contact Member Services at the number on the member's ID card or review our Medical Management page.
An approved prior authorization is required before obtaining services from non-plan providers.