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 10 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 Member Services at the number on the member's ID card or visit our Medical Management page
An approved prior authorization is required before obtaining services from non-plan providers.

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