

My Choice Wisconsin– BH Pre Service Request Form Fax to 608-210-4050

MEMBER INFORMATION

Line of Business:	<input type="checkbox"/> Medicaid	<input type="checkbox"/> Medicare	<input type="checkbox"/>	Date of Request:
Member Name:				DOB (MM/DD/YYYY):
Member ID#:				Member Phone:
Service Type:	<input type="checkbox"/> Non-Urgent/Routine/Elective <input type="checkbox"/> Urgent/Expedited – Clinical Reason for Urgency Required: _____ <input type="checkbox"/> Emergent Inpatient Admission			

REFERRAL/SERVICE TYPE REQUESTED

Request Type:	<input type="checkbox"/> Initial Request	<input type="checkbox"/> Extension/ Renewal / Amendment	Previous Auth#:
Inpatient Services:	Outpatient Services:		
<input type="checkbox"/> Inpatient Psychiatric <input type="checkbox"/> Involuntary <input type="checkbox"/> Voluntary <input type="checkbox"/> Inpatient Detoxification <input type="checkbox"/> Involuntary <input type="checkbox"/> Voluntary If Involuntary, Court Date: _____	<input type="checkbox"/> Residential Treatment <input type="checkbox"/> Partial Hospitalization Program <input type="checkbox"/> Intensive Outpatient Program <input type="checkbox"/> Day Treatment		<input type="checkbox"/> Electroconvulsive Therapy <input type="checkbox"/> Psychological/Neuropsychological Testing <input type="checkbox"/> Applied Behavioral Analysis <input type="checkbox"/> Non-PAR Outpatient Services <input type="checkbox"/> Other: _____

PLEASE SEND CLINICAL NOTES AND ANY SUPPORTING DOCUMENTATION

Primary ICD-10 Code for Treatment: _____ **Description:** _____

DATES OF SERVICE		PROCEDURE/ SERVICE CODES	DIAGNOSIS CODE	REQUESTED SERVICE	REQUESTED UNITS/VISITS
START	STOP				

PROVIDER INFORMATION

REQUESTING PROVIDER / FACILITY:

Provider Name:		NPI#:	TIN#:	
Phone:	FAX:		Email:	
Address:		City:	State:	Zip:
PCP Name:			PCP Phone:	
Office Contact Name:			Office Contact Phone:	

SERVICING PROVIDER / FACILITY:

Provider/Facility Name (Required):				
NPI#:	TIN#:	Medicaid ID# (If Non-Par):	<input type="checkbox"/> Non-Par <input type="checkbox"/> COC	
Phone:	FAX:		Email:	
Address:		City:	State:	Zip:

Obtaining authorization does not guarantee payment. The plan retains the right to review benefit limitations and exclusions, beneficiary eligibility on the date of the service, correct coding, billing practices and whether the service was provided in the most appropriate and cost-effective setting of care.