



# MY CHOICE WISCONSIN BADGERCARE PLUS AUTHORIZATION FORM

\* STANDARD                       \*\* EXPEDITED/URGENT

\*Determination to be made within 14 business days

\*\*Determination to be made within one calendar day. Faxes received after 4 pm will be reviewed next business day by 12 pm.

DATE OF SCHEDULED APPOINTMENT: \_\_\_\_\_

Date: \_\_\_\_\_ Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Requesting Provider Name/Clinic: \_\_\_\_\_ Tax ID: \_\_\_\_\_

Address: \_\_\_\_\_

Clinical Contact/Title: \_\_\_\_\_ Phone Number: \_\_\_\_\_ Fax: \_\_\_\_\_

Servicing Provider Name/Clinic: \_\_\_\_\_ Tax ID: \_\_\_\_\_

Address: \_\_\_\_\_

Clinical Contact/Title: \_\_\_\_\_ Phone Number: \_\_\_\_\_ Fax: \_\_\_\_\_

Facility Name: \_\_\_\_\_ Facility Address: \_\_\_\_\_

Facility Tax ID: \_\_\_\_\_ Facility NPI: \_\_\_\_\_

Requested Dates:                      From: \_\_\_\_\_                      To: \_\_\_\_\_                      Units/Visits: \_\_\_\_\_

Diagnosis (ICD-10): \_\_\_\_\_

Procedure (CPT/HCPCS/Units): \_\_\_\_\_

**Type of Authorization:**

- |   |   |  |                                       |
|---|---|--|---------------------------------------|
| <input type="checkbox"/> Observation (Non Par Only) | <input type="checkbox"/> Pre-Authorization        | <input type="checkbox"/> Sub Acute Admission | <input type="checkbox"/> DME Purchase |
| <input type="checkbox"/> Case Management            | <input type="checkbox"/> Referral                 | <input type="checkbox"/> Transplant          | <input type="checkbox"/> DME Rental   |
| <input type="checkbox"/> Inpatient Rehabilitation   | <input type="checkbox"/> Non-Emergency Transport  | <input type="checkbox"/> DME Repair          |                                       |
| <input type="checkbox"/> Maternity                  | <input type="checkbox"/> Second Opinion           | <input type="checkbox"/> Home Health Care    |                                       |
| <input type="checkbox"/> Outpatient Surgery         | <input type="checkbox"/> Skilled Nursing Facility | <input type="checkbox"/> Therapy (PT/OT/ST)  |                                       |
| <input type="checkbox"/> Inpatient                  | <input type="checkbox"/> LTAC                     |  |                                       |

**The following authorizations require the additional documentation listed to be faxed along with this form:**

- Diagnostic Procedures - Physician Order & Clinical Documentation
- DME (Purchase or Rental) - Physicians Order & State Prior Auth/Oxygen Attachment & Face-to-Face (F2F)
- DME (Repair) - Physicians Order and Work Order & Face-to-Face (F2F)
- Home Health – 485 Form & Face-to-Face (F2F)
- Hospice – State Physician Certification & Recertification of Terminal Illness
- PCW – PA/RF & HCAF & 485 & PCW Instructions
- Inpatient Rehabilitation/SAR– Physician Order & Initial Evaluation
- RN Supervisory – PA/RF & HCAF & 485 & PCW Instructions
- Therapy (PT/OT/SP) requires Physician Order & Initial Evaluation & Face-to-Face (F2F)

**FAX Form and other pertinent documents to IPN at (414) 771-1159**

**To check authorization status for your submitted request please contact customer service at 414-755-3619 and select Provider and then select Customer Service**

**Please Note:**

- All authorizations for in-network and out-of-network services must be faxed to IPN and approved before services are provided.
- Authorization for Medically Necessary Services is NOT a guarantee of eligibility or payment.

(No authorization may exceed 180 days from date authorized without prior approval)

CONFIDENTIALITY NOTE: This form contains privileged and confidential information intended only for the use of the addressee. If you are not the intended recipient, or the employee or agent responsible for delivering it to the intended recipient, you are hereby notified that reading it is strictly prohibited. If you have received this information in error, please immediately return it to the sender and delete it from your system. Thank you.