my choice
WISCONSIN
Health Plan

BadgerCare Plus Authorization Request Form
Day Treatment/Partial Hospitalization

Patient's Name: _____ DOB: __/__/__ ID# _____

*Please attach clinical information including medications and fax all to (608) 245-3097.

Diagnosis Code(s):   Date of Admission __/__/__

_____   Estimated Length of Stay: _____

_____   ☐ Mental Health   ☐ AODA

_____

Past Levels of Care Attempted:

Outpatient? If yes, when and where: _____

Inpatient? If yes, when and where: _____

Provider Name: _____

Facility Name: _____ NPI: _____

Address: _____ Tax ID: _____

Contact Name _____

Phone: _____   Fax: _____

Health Check screening documentation is required with this request. Members without a Health Check screening performed within the past 12 months will not be approved for this service. General follow up or problem focused appointments with a primary care provider do not qualify as a Health Check.

The submission of supporting clinical documentation/plan of care is required with this form.