my choice WISCONSIN BY MOLINA HEALTHCARE

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

## MEMBER INFORMATION

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

## REFERRAL/SERVICE TYPE REQUESTED

| | | | |
|---|---|---|---|
| **Request Type:** | ☐ **Initial Request** | ☐ **Extension/ Renewal / Amendment** | **Previous Auth#:** |

| **Inpatient Services:** | **Outpatient Services:** | |
|---|---|---|
| ☐ Inpatient Psychiatric<br>☐Involuntary ☐Voluntary<br>☐ Inpatient Detoxification<br>☐Involuntary ☐Voluntary<br><br>If Involuntary, Court Date:_____ | ☐ Residential Treatment<br>☐ Partial Hospitalization Program<br>☐ Intensive Outpatient Program<br>☐ Day Treatment | ☐ Electroconvulsive Therapy<br>☐ Psychological/Neuropsychological Testing<br>☐ Applied Behavioral Analysis<br>☐ Non-PAR Outpatient Services<br>☐ Other: _____ |

## PLEASE SEND CLINICAL NOTES AND ANY SUPPORTING DOCUMENTATION

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

| DATES OF SERVICE START | STOP | PROCEDURE/ SERVICE CODES | DIAGNOSIS CODE | REQUESTED SERVICE | REQUESTED UNITS/VISITS |
|---|---|---|---|---|---|
| | | | | | |
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## 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):** | ☐**Non-Par** ☐**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.