

Prior Authorization Request

If you are having trouble accessing the new Guiding Care Provider Authorization Portal please use this form to submit any **URGENT** requests.

Once you have completed all fields of this form, please fax this form and any relevant clinical information to 414-266-4726.

- An approved request does not authorize payment of non-covered or exhausted benefits.
- All fields are required.

Member Information (all sections must be completed or it will be returned without review)					
Member Name:		Member ID#:			
Member Address:		Member Date of Birth:			
City:		State:			
Phone:		Zip Code:			
Referring Provider Information					
Name:		Phone Number:			
Address:		Fax Number:			
City:		State:		Zip Code:	
Service Facility Information					
Name:		Phone Number:			
Address:		Fax Number:			
City:		State:		Zip Code:	
Facility NPI:		Facility Tax ID:			
Service Provider Information					
Name:		Phone number:			
Address:		Fax Number:			
City:		State:		Zip Code:	
Provider NPI:		Provider Tax ID:			
Specialty:					

Service Provider Information

List of in-plan providers that the member has already seen:			
Reason care cannot be provided in-network:			
Diagnosis code(s):		Diagnosis description:	
Start Date:		End Date:	

Service(s) Requested

Must include all CPT/HCPCS codes and number of visits/units for each code requested.

- Medical Inpatient
 Medical Outpatient
 Behavioral Health Inpatient
 Behavioral Health Day Treatment
 Transplant Service
 Hospice
 Home Care
 Dialysis
 DME
 Pharmacy

Number of visits/units	CPT / HCPCS code	Number of visits/units	CPT / HCPCS code