Coverage Determination Request Form

Please fill out this form completely and send it to ***i*Care Health Plan**

Fax: 414-231-1026
email: paassistants@icarehealthplan.org
Mail: 1555 N. RiverCenter Dr. Suite 206
Milwaukee, WI 53212
Attn: PA Department

Urgency:	☐ Elective/Routine (7-day turnaround time)	☐ Expedited/Urgent* (72-hr. turnaround time)

Definition of Urgent/Expedited:** when the treatment requested is required to prevent imminent, serious deterioration in the member's health or threatens to jeopardize the member's ability to regain maximum function. ***iCare reserves the right to deny the request for urgent review for all requests outside of this definition.

Member Information			
Member Name:		DOB:	
Medicare ID:		Phone:	
Mailing Address:		City:	
State:		Zip:	

Physician Information If the member has previously seen a provider regarding the requested service/item, please provide their information below.			
Physician Name:		Phone:	
Address:		City:	
State:		Zip:	

Services/Items Requested Provide as much detail as possible. Attach additional pages, if needed.

Form continued on next page

INDEPENDENT CARE HEALTH PLAN
*i*Care is a wholly-owned subsidiary of Humana

Reason for request: *(Attach additional pages as needed)*	
Signature of iCare Member *or* **Legal Representative**:	**Date**:
Signature of Witness *(only needed if member signed with an "X")*:	**Date**:

*** If signed by a legal representative, please complete***

Member is one or more of the following (Check all that apply)**:**

☐ Minor	☐ Incompetent	☐ Incapacitated	☐ Deceased

Nature of Legal Authority (Check all that apply)**:**

☐ Custodial Parent	☐ Legal Guardian	☐ Activated Power of Attorney for Healthcare	☐ Executor of Estate of Deceased

***NOTE**: When the member is an adult and you are signing as the legal representative, proof is required of the legal representative relationship in order to release information. Attach Guardianship, Power of Attorney – Health Care, or Executor paperwork as documentation.*

THIS DOCUMENT WILL NOT BE HONORED UNLESS ACCOMPANIED BY THE REQUIRED DOCUMENTATION.

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www.icarehealthplan.org