INDEPENDENT CARE HEALTH PLAN

Prior Authorization Request Form

Receipt of an approved prior authorization does not guarantee coverage or payment by *i*Care
Benefits are determined based on the dates that the services are rendered

Please fill out this form completely and fax to:

(414) 231-1026

For PA Status call Customer Service at 414-223-4847

iCare Prior Authorization Department 414-299-5539 or 855-839-1032

An incomplete form may delay processing and/or claims payment

Member Information		
Member Name:		**DOB:**
Member ID#:		**Phone:**
Service Type:	☐ Elective/Routine (14-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.

Servicing Provider Information		
Provider/ Supplier Name:		NPI:
Contact at Provider or Supplier:	Tax ID Number:	Phone:
Address:		Fax:
Requesting Provider Information		
Provider/ Supplier Name:		NPI:
Contact at Provider or Supplier:	Tax ID Number:	Phone:
Address:		Fax:

Referral/Service Type Requested		
Outpatient Therapy ☐ PT* ☐ OT* ☐ ST* ☐ Cardiac Rehab* ☐ Pulmonary Rehab* ***Date of initial eval:** ____	☐ Procedure ☐ Personal Care Worker (PCW) ☐ Home Health/Hospice ☐ Referral or Second Opinion ☐ Urine Drug Screen	**DME Please Select One:** ☐ New Rental ☐ Continued Rental ☐ Purchase ☐ Replacement ☐ DMS Overage

ICD 10 Diagnosis Code & Description:	**CPT/HCPC: Code**	**Description**	**# of Units, hrs/days**

Date of Service	From:	To:	Number of Visits:

Comments (please do not mark level of urgency here, see top of form):

Clinical Notes, Supporting Documentation, and Physician Order are Required to Review for Medical Necessity