

## Behavioral Health Prior Authorization Request Form

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

### Member Information

Member Name:	DOB:
Member ID #:	Phone:

**Definition of Urgent/Expedited:** when the treatment requested is required to prevent imminent, serious deterioration in the member's health or threaten 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 (facility/ supplier who will perform service/procedure)

Provider/Supplier Name:		NPI:
Contact Name:	Tax ID Number:	Phone:
Address:		
Email:		Fax:

### Ordering Practitioner Information (practitioner who ordered service/procedure)

Practitioner Name:		NPI:
Contact Name:	Tax ID Number:	Phone:
Address:		
Email:		Fax:

### Referral/ Service Request Type

<b>Inpatient Behavioral Health</b> <input type="checkbox"/> Initial <input type="checkbox"/> Transfer <input type="checkbox"/> Retrospective <input type="checkbox"/> Voluntary <input type="checkbox"/> Emergency/Involuntary <input type="checkbox"/> Court Ordered Service <b>Court Date:</b> _____ <input type="checkbox"/> Forensic Admission <b>Admit Date:</b> _____ <b>Time</b> _____	<b>PHP/IOP</b> <input type="checkbox"/> H2012 _____ units <input type="checkbox"/> H2019 _____ units <b>Requested Dates of Service:</b> From: _____ To: _____	<b>Service Type</b> <input type="checkbox"/> Expedited/ Urgent (72-hr turnaround time) <input type="checkbox"/> Elective Routine (7-day turnaround time) <input type="checkbox"/> Court Ordered Service (72-hr turnaround time) <input type="checkbox"/> Clinical Trial (72-hr turnaround time)
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☐ **Continuity/Transition of Care request** (Please check if this request for an active course of treatment previously approved by another insurance carrier/ Medicare HMO)

### ICD 10 Diagnosis Code and Description:

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

**Clinical Notes, Supporting Documentation, and Physician Orders are Required to Review for Medical Necessity. In Addition, Providers Must Complete the Outpatient Mental Health Assessment and Treatment/Recovery Form or Provide Equivalent Clinical Information that Addresses all Required Elements of the Form. The Form is Available on the ForwardHealth Website at the Link Below.**

<https://www.forwardhealth.wi.gov/kw/html/MHTrmtRecoveryPlan.html>

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

An incomplete form may delay processing and/or claims payment.

**INDEPENDENT CARE HEALTH PLAN**

1555 N RiverCenter Dr. Suite 206 Milwaukee, WI 53212

[www.iCareHealthPlan.org](http://www.iCareHealthPlan.org)

Updated 12/11/25