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

# 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**
*i*Care 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**

| **Inpatient Behavioral Health** | **PHP IOP** | **Service Type** |
|---|---|---|
| **Admit Date:**<br>**Admit Time:**<br>□Initial □Transfer □Retrospective<br>□Voluntary<br>□Emergency/Involuntary | □H2012 _____ units<br>□H2019 _____ units<br><br>**Requested Dates of Service**: From: _____<br>To: _____ | □Expedited/ Urgent (72-hr turnaround time)<br>□Elective Routine (7-day turnaround time)<br>□Court Ordered Service (72-hr turnaround time)<br>□Clinical Trial (72-hr turnaround time)<br>□Court Ordered Service<br>**Court Date**: _____<br>□Forensic Admission |

□ **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.*