Other Medical Services Prior Authorization Request Form

For PACE Program and FC Partnership Program Members ONLY

This form should be used for those services that require a prior authorization as indicated on the CCI Prior Authorization Requirement Document and do not have a procedure specific authorization request form.

Please complete the PA form and fax along with supporting clinical documentation to: Community Care Team Fax: 888-661-6851, Phone: 414-0231-4000, please call and ask for member's Interdisciplinary Team Staff (IDTS) with any questions.

Incomplete forms or lack of supporting clinical may cause delay in determination or administrative denial for lack of clinical information.

Member Name:	D.O.B:	Medicare ID #: Medicaid ID #:
Member Phone:	Member Address:	
Requesting Provider Name/Clinic:		
Address and email:		
Clinical Contact/Title:	Phone Number:	Fax Number:
Servicing Provider Name/Clinic:		Tax ID:
Address:		
Clinical Contract/Title:	Phone Number:	Fax Number:

Request Type	
☐ Standard ☐ Expedited	Expedited is defined as: Care and services that provide the physician indicates or the HMO determines that following the ordinary time frame could jeopardize the member's health or ability to regain maximum function.
Please explain rationale for the urgency:	

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Request Information				
Diagnosis or Symptom Information:				ICD-10:
CPT/HCPC code:	Description:	Qty/Freq:	Start Date:	End Date:
CPT/HCPC code:	Description:	Qty/Freq:	Start Date:	End Date:

Description of service being requested
Please also fax any supporting clinical documentation:

205 Bishops Way, Brookfield, WI 53005 ● Phone: 262-207-9393 ● Fax: 414-384-8272