



## Bariatric and Transplant Surgery Prior Authorization Request Form

**For Family Care Partnership Program Members ONLY**

**Please complete this form and fax along with supporting clinical documentation to: Community Care Utilization Management Fax: 414-384-8272, phone: 262-207-9393, please call UM 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:		
Clinical Contact/Title:	Phone Number:	Fax Number:
Servicing Provider Name/Clinic:		
Tax ID:	NPI #:	
Address:		
Clinical Contract/Title:	Phone Number:	Fax Number:

Request Type		
<input type="checkbox"/> Standard	<input type="checkbox"/> 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:		

Privacy and confidentiality: The information within this fax message is intended for the recipient(s) only. If you have received this fax in error, please contact us at 262-207-9393 (phone) or 414-384-8272 (fax) and destroy this document received. State and Federal Law prohibits any unauthorized use of this information. Thank you for your cooperation.

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



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**This form is ONLY needed for the following codes listed below requiring UM review: Bariatric - 43290, 43291, 43644, 43645, 43659, 43770, 43771, 43772, 43773, 43774, 43775, 43842, 43843, 43845, 43846, 43847, 43848, 43886, 43887, 43888, and 43999. Transplant Lung, Blood, bone marrow, renal - 32851, 32852, 32853, 32854, 38206, 38230, 38232, 50370, and L8698.**

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

**Please Select One:**

Anticipate Outpatient Service Only.

Anticipate Observation stay for \_\_\_\_\_ hours.

Anticipate Inpatient Admission for \_\_\_\_\_ days.      Anticipated Date of Admission: [Click or tap to enter a date.](#)

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