GENETIC and MOLECULARPATHOLOGY TESTING Prior Authorization Request

For PACE Program and FC Partnership Program Members ONLY

For Family Care (LTC) members call 1-866-937-2783 and ask to speak to the member's Interdisciplinary Team Staff (IDTS) about authorization requirements. CCI UM does not review or authorize any services for the LTC program.

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:
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:	
HCPC code:	Description:	Qty/Freq:	Start Date:	End Date:
HCPC code:	Description:	Qty/Freq:	Start Date:	End Date:
HCPC code:	Description:	Qty/Freq:	Start Date:	End Date:
HCPC 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:

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