Clear Print

Other Medical Services Prior Authorization Request

For PACE and Partnership Members ONLY

This form should be used for those services that require a prior authorization as indicated on the CCI coverage matrix 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: 414-231-4000, please call and ask for member's team with any questions.
Incomplete forms or lack of supporting clinical documentation may cause delay in determination or administrative denial for lack of clinical information.

Member Name:	DOB:	Medicaid #:
Member Phone:	Member Address:	
Requesting Provider Name/Clinic:		Tax ID:
Address:		
Clinical Contact/Title:	Phone Number:	Fax Number:
Email:		
Servicing Provider Name/Clinic:		Tax ID:
Address:		
Clinical Contact/Title:	Phone Number:	Fax Number:

Request Type? ☐ Standard ☐ Expedited: Please explain rationale for urgency:
Expedited is defined as: Care and services that 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.

Diagnosis or symptom description: ICD-10:

CPT/HCPC code requested:	Description:	Quantity:	Start Date:	End Date:
CPT/HCPC code requested:	Description:	Quantity:	Start Date:	End Date:

Description of service being requested.

Please also fax any supporting clinical documentation.

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 414-231-4000 (phone) or 888-661-6851 (fax) and destroy this document received. State and Federal Law prohibits any unauthorized use of this information. Thank you for your cooperation.