



We care for Wisconsin.

UNDERWRITTEN BY WPS HEALTH PLAN, INC.

PRE-SERVICE AUTHORIZATION REQUEST

Approved _____ Amended _____ Denied _____
Reason: _____
Medical Staff/Date: _____

ALL PRE-SERVICE AUTHORIZATION REQUESTS ARE SUBJECT TO REVIEW. Under the provision of the plan, all authorizations must be approved by the Plan Medical Director or an authorized designee prior to dates of service requested. Individuals may be subject to additional out-of-pocket expense up to the limits of their plan, if authorization is not approved prior to services received or if receiving services from a nonparticipating provider. PRE-SERVICE AUTHORIZATION DOES NOT APPLY TO SERVICES OR CHARGES WHICH ARE EXCLUDED BY THE PLAN.

RETROACTIVE AUTHORIZATION REQUESTS WILL NOT BE AUTHORIZED

Please Complete all sections:

Patient Name: _____ Date of Birth: _____
Subscriber Name: _____ Subscriber #: _____
Patient Home Phone #: _____ Employer: _____

Referred To: _____
Provider Name
Address
Telephone Number

Working Diagnosis / ICD9: _____
Clinical history including pertinent diagnostic testing/treatment necessitating pre-service authorization request/extension:
Authorization request for: _____ Consultation _____ Lab, X-Ray, Testing _____ Treatment/Therapy _____ Surgery
Limitations/restrictions on the services authorized: _____
This authorization request is for the following: _____ visits from _____/_____/_____ to _____/_____/_____
*Special requests: _____
Referred By: _____ MD
Print Name Physician Contact Phone Number
Physician's Signature _____ MD
Physician Office Contact Person
Date Telephone Number

ALL HOSPITAL INPATIENT ADMISSIONS REQUIRE PRE-SERVICE AUTHORIZATION:
Call 1-888-711-1444 toll-free or 920-490-6900 local

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Fax or Mail to:

Arise Health Plan
PO Box 11625 · Green Bay, WI 54307-1625
1-888-711-1444 toll-free, 920-490-6900 local
Fax: 920-490-6943

For office use only:
Case # _____
Completed by: _____