Medicare Advantage Plans – Prior Authorization Request Form

Fax completed form to: 1-608-252-0840

Choose Type of Service:

Durable Medical Equipment	**Skilled Nursing Facility**	**Outpatient**	**Medical Drug Injectable**	**Elective Admissions includes Acute Rehab & LTAC**

Choose One:

Standard Request - Determination will be made within 14 calendar days after receipt of the request

Expedited Request - Waiting for a decision risks the member's life, health or pain that cannot otherwise be managed

Emergency Admission Notification – Emergency services do not require prior authorization

PATIENT DEMOGRAPHICS

Patient Name:		Date of Birth:
Member ID:		Phone Number:
Street Address:		
City:	State:	ZIP Code:

REFERRING PROVIDER INFORMATION

Provider Name:	Provider #:	Specialty:	Phone #:
Street Address:			Fax #:
City:	State:		ZIP Code:
Provider #:	Specialty:		

REFERRED TO PHYSICIAN/FACILITY/PROVIDER INFORMATION

Referred To:	Specialty:	Phone #
Street Address:		Fax #
City:	State:	ZIP Code:

REQUEST INFORMATION

Date (s) of Service:	Number of Visits:
CPT Code(s):	Diagnosis Code(s):

Durable Medical Equipment Description	HCPCS	Quantity	Rental or Purchase

Skilled Nursing Facility
Member Admitted From:
Number of Medicare SNF days utilized during this benefit year:

Medical Drug Injectable	HCPCS	Dosage	Frequency	Place of Service	Expected Length of Therapy

Required Explanation Provide in Additional Information below	**Alternate drug(s) contraindicated or previously tried, but with adverse outcome (e.g. toxicity, allergy, or therapeutic failure)** – Supply documentation for (1) Drug(s) contraindicated or tried; (2) adverse outcome for each; (3) if therapeutic failure, length of therapy on each drug(s) **Complex patient with one or more chronic conditions (for example, psychiatric condition, diabetes) is stable on current drug(s)** – Include anticipated significant adverse clinical outcome Other:

Additional Information:

Form Submitted By:	Phone:	Fax:

Fax form to: **1-608-252-0840** or Mail to: Dean Health Plan, Attn: Utilization Management, PO Box 56099, Madison, WI 53705-9399

Include any clinical or office notes that would support this request. Requests to non-plan providers must be approved prior to obtaining services. Updated: 4/22/2022