



Authorization Request Form Day Treatment/Partial Hospitalization

Patient's Name: _____ DOB: ___ / ___ / ___ ID# _____

***Please attach clinical information including medications and fax all to (608) 245-3097.**

Diagnosis Code(s):

Date of Admission ___ / ___ / ___

Estimated Length of Stay: _____

Mental Health AODA

Past Levels of Care Attempted:

Outpatient? If yes, when and where: _____

Inpatient? If yes, when and where: _____

Provider Name: _____

Facility Name: _____ NPI: _____

Address: _____ Tax ID: _____

Contact Name _____

Phone: _____ Fax: _____

Health Check screening documentation is required with this request. Members without a Health Check screening performed within the past 12 months will not be approved for this service. General follow up or problem focused appointments with a primary care provider do not qualify as a Health Check.

The submission of supporting clinical documentation/plan of care is required with this form.

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 414-771-6177 and destroy this document received. State and Federal Law prohibits any unauthorized use of this information. Thank you for your cooperation.