Reset Form

PRE-DETERMINATION REQUEST FORM (MEDICARE ONLY)

FYI: ***Incomplete, illegible, or inaccurate forms will be returned to the sender.*** Please complete the entire form and submit documentation to support medical necessity along with this request. Failure to provide required documentation may result in denial of the request. Review our provider manual criteria references.

◯ **Medical Services**	◯ **Mental Health and Substance Use Disorder Services**
Fax form and relevant clinical documentation to: 715.787.7316	Fax form and relevant clinical documentation to: 715.787.7314
For questions, call: 715.631.7412 or 1.855.931.4851	For questions, call: 715.631.7442 or 1.855.931.5264

PATIENT INFORMATION:		
Name:		
Member ID:	PMI:	
Address:		
City:	State:	Zip Code:
Date of Birth:	Phone:	
Member Health Plan (required)*:		

ORDERING PRACTITIONER/CLINIC INFORMATION:		
Ordering Practitioner Name:	Clinic NPI Number:	
Clinic Name:		
Ordering Practitioner Address:		
City:	State:	Zip Code:
Phone:	Fax:	

SERVICING CLINIC INFORMATION:		
Servicing Practitioner Name:		
Servicing Practitioner Clinic Location Name (required)*:		
Clinic Location NPI Number (required)*:		
Clinic Location Address:		
City:	State:	Zip Code:

CONTACT PERSON FOR PRIOR AUTHORIZATION QUESTIONS:	
Name:	
Phone:	Fax:
Email:	

REASON FOR PRE-DETERMINATION REQUEST: (SELECT ONE)

- ☐ Service/Procedure does not meet Original Medicare Necessity Criteria
- ☐ Service/Procedure is not covered by Original Medicare
- ☐ Benefit Exception
- ☐ Investigative or experimental procedure:
- ☐ Other:

CPT/HCPC				
CPT/HCPC Code(s)	# of Units/Visits Requested	Start Date	End Date	Frequency
ICD-10 Diagnosis Codes				

Description of Request:

Place of Residence:
◯ Skilled Nursing Facility (SNF) ◯ Assisted Living Facility ◯ Home/Apartment ◯ Group Home ◯ Other

PLEASE SELECT STANDARD OR EXPEDITED REQUEST BELOW

◯ STANDARD REQUEST

- Medicare decision within 10 business days.

◯ EXPEDITED REQUEST

- Only request an urgent/emergent review if waiting for the standard review timeframe would potentially jeopardize the member's health, life, or ability to regain function.
- Medicare decision within 72 hours.
- Billing and retrospective authorizations are not expedited.

1. Proposed date of service: _____
   - Billing and retrospective authorizations are not expedited.
2. Clinical reason for urgency (**unrelated to scheduling issues**):
3. Provide a contact name and number available for this request:
   - Due to the expedited processing time, please ensure that the designated contact is readily accessible should further information be required.

CONFIRM AND COMPLETE THE REQUIRED STEPS TO PROCEED:

☐ Clinical notes supporting any of the above have been included in the submission form.
(Incomplete submission can delay decision time)

Physician/Practitioner Signature _____ Date _____

Notes: Do not use this form for Injectable Drug Authorization Requests, DME Authorization, Home Care Services.

Please refer to Aspirus.org for appropriate forms.