



**PRE-SERVICE AUTHORIZATION REQUEST**

**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.**

**Please attach any medical records to support the pre-service authorization request. Failure to do so can result in a delay in completing the review of the request.**  
**\*\*RETROACTIVE AUTHORIZATION REQUESTS WILL NOT BE AUTHORIZED\*\***

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Subscriber Name: \_\_\_\_\_ Subscriber #: \_\_\_\_\_  
Patient Home Phone #: \_\_\_\_\_ Employer: \_\_\_\_\_

Referred To: \_\_\_\_\_ Appointment Date (if known) \_\_\_\_\_  
Provider Name \_\_\_\_\_  
Street Address \_\_\_\_\_ Telephone Number \_\_\_\_\_  
City, State, Zip \_\_\_\_\_

Working Diagnosis: \_\_\_\_\_  
CPT Code: \_\_\_\_\_  
**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 \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Referred By: \_\_\_\_\_ MD \_\_\_\_\_ Physician Contact Phone Number  
Print Name \_\_\_\_\_  
\_\_\_\_\_ MD \_\_\_\_\_ Physician Office Contact Person  
Physician's Signature \_\_\_\_\_  
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 additional questions regarding Arise Health Plan services and policies visit: [www.wecareforwisconsin.com](http://www.wecareforwisconsin.com)