

Prior Authorization and Referral Request Form

For quicker response, please submit this request electronically via iExchange and attach the supporting clinical documents.

<https://nexalignexchange.meddecision.com/IEApp/login/providerLogin.faces>

If faxing (non-preferred), please fax completed form and applicable supporting clinical documents to the appropriate fax number below.



Arise Members:

Arise Health Plan-Attn: Integrated Care Management
 P.O. Box 11625 • Green Bay, WI 54307-1625
 Phone: 888-711-1444 • Fax: 608-327-6300

Date of Request
Start Date of Service

This request is for:	Authorization	Referral
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MEMBER INFORMATION

First Name	Last Name	Date of Birth	Subscriber Number
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ORDERING/REFERRING PROVIDER INFORMATION

Provider First Name	Site/Location Name		
Provider Last Name	Site/Location Address		
TIN	NPI	City	State ZIP
Location Contact Person	Phone	Fax	

Fax notifications related to this request (by checking this box, you will not receive mail notifications).

PRIOR AUTHORIZATION INFORMATION Check if servicing provider is same as ordering provider.

Servicing Provider First Name	Site/Location Name		
Servicing Provider Last Name	Site/Location Address		
TIN	NPI	City	State ZIP
Location Contact Person	Phone	Fax	

Comments (indications for treatment)

REFERRAL INFORMATION

Reason for Referral:	Patient's Request	MD Preference	Unavailable in Network	Health Plan Requirement
Referred to Provider First Name	Site/Location Name			
Referred to Provider Last Name	Site/Location Address			
TIN	NPI	City	State	ZIP
Location Contact Person	Phone	Fax		

Comments (indications for referral to specialist)

SERVICES REQUESTED (Supporting clinical documentation must accompany this request)

Consult Only	Follow-Up	DME	Lab/X-Ray	Home Care	Hospice	Skilled Nursing
Surgery:	Inpatient	Outpatient	Other			
Primary Diagnosis Code	Description					
Procedure/HCPSC Code(s)	Description					

Attach Applicable Office Notes and Diagnostic Testing Results For This Request

Workers Compensation	Yes	No	Date of Injury/Loss
Motor Vehicle Accident/Subro	Yes	No	Date of Injury/Loss
Other Coverage	Yes	No	Insurance Company

NOTE: The prior authorization of any procedure does not guarantee benefits or payment. Approval is based on medical necessity as defined in the patient's benefit plan or certificate. All benefits are subject to the terms, conditions, and exclusions of the benefit plan or certificate. This may include policy language regarding pre-existing conditions or signed affidavits stating that the insurance bears no responsibility, as signed by the insured. Policy exclusions for certain types of services may also apply. Verify prior authorization requirements. For additional benefit information, please contact Arise Health Plan at 888-711-1444. **A release of information form included in the application for insurance was signed by our member.**

