WPS REFERRAL AUTHORIZATION REQUEST

All referral requests are subject to medical review. Under the provisions of the Plan, the Plan Utilization Management Team or the Plan Medical Director must authorize services provided by non participating providers (also participating specialty providers for Prime Care) or services at non-participating locations to allow payment at the member's higher level of benefit.

Plan patients are responsible for payment of the portion(s) of the submitted charge(s) by the selected non-participating provider that in excess of the usual and customary fee. Authorization does not apply to the services or charges that are excluded by the Plan provisions.

Attention: Please fully complete form to avoid delays in processing.

Patient Name: ______________________________ DOB: ______________

Member Name : ______________________________ Customer Number: ______________

Patient Home Phone # (______) __________________

Referral Request;: URGENT __________ ROUTINE __________

Referred To: ______________________________ ______________

Provider Name (last, first) Specialty

______________________________ ______________

Street Address Telephone Number

______________________________ ______________

City, State, Zip Tax Identification Number

Reason for referral : ____ Patient Preference ____ MD Preference ____ Services unavailable with participating providers

____ Other ______________________________

Patient Diagnosis / ICD9: ______________________________

CPT Code(s): ______________________________

Clinical history including pertinent diagnostic testing, prior treatment and rationale for referral request: ______________

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Referral Requested For: ____ Consultation ____ Lab/X-ray/Testing ____ Treatment/Therapy ____ Surgery

Dates of Service: __________________ to __________________ Number of Visits: __________

Referred by: ______________________ ______________ ______________

Print Physician's Name Phone Number Office Contact

______________________ ______________ ______________

Street Address Fax Number Office Contact Phone

______________________ ______________

City, State, Zip Today's Date

If you have any questions, please call
WPS Health Insurance **at 1-800-333-5003**

WPS Health Insurance - 1717 West Broadway Madison, WI 53718 – Fax (608-226-4777)