

**WISCONSIN MEDICAID  
 PRIOR AUTHORIZATION REQUEST FORM (PA/RF)**

Providers may submit prior authorization (PA) requests by fax to Wisconsin Medicaid at (608) 221-8616; or, providers may send the completed form with attachments to: Wisconsin Medicaid, Prior Authorization, Suite 88, 6406 Bridge Road, Madison, WI 53784-0088. **Instructions:** Type or print clearly. Before completing this form, read your service-specific Prior Authorization Request Form (PA/RF) Completion Instructions.

<b>FOR MEDICAID USE ?ICN</b>	AT	Prior Authorization Number
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<b>SECTION I — PROVIDER INFORMATION</b>		
1. Name and Address — Billing Provider (Street, City, State, Zip Code)  <b>I. M. Provider          1 W. Williams          Anytown, WI 55555</b>	2. Telephone Number ? Billing Provider <b>(XXX) XXX-XXXX</b>	3. Processing Type  <b>120</b>
4. Billing Provider's Medicaid Provider Number <b>12345678</b>		

<b>SECTION II — RECIPIENT INFORMATION</b>		
5. Recipient Medicaid ID Number <b>1234567890</b>	6. Date of Birth — Recipient (MM/DD/YY) <b>MM/DD/YY</b>	7. Address — Recipient (Street, City, State, Zip Code) <b>609 Willow          Anytown, WI 55555</b>
8. Name — Recipient (Last, First, Middle Initial) <b>Recipient, Im A.</b>		9. Sex — Recipient <input type="checkbox"/> M <input checked="" type="checkbox"/> F

<b>SECTION III — DIAGNOSIS / TREATMENT INFORMATION</b>									
10. Diagnosis — Primary Code and Description <b>250.00 — Diabetes II (NIDDM type)</b>				11. Start Date — SOI		12. First Date of Treatment — SOI			
13. Diagnosis — Secondary Code and Description <b>401.9 — Hypertension NOS</b>				14. Requested Start Date <b>MM/DD/YY</b>					
15. Performing Provider Number	16. Procedure Code	17. Modifiers				18. POS	19. Description of Service	20. QR	21. Charge
	99600	1	2	3	4	12	HHN - initial visit, 1 visit/day x 3 days/wk x 3 wks	12 visits	XXX.XX
							3 PRN visits/month x 1 month		

An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after the authorization expiration date. Reimbursement will be in accordance with Wisconsin Medicaid payment methodology and policy. If the recipient is enrolled in a Medicaid HMO at the time a prior authorized service is provided, Medicaid reimbursement will be allowed only if the service is not covered by the HMO.

23. SIGNATURE — Requesting Provider <div style="text-align: center; font-size: 1.2em; font-family: cursive;">IM Provider</div>	24. Date Signed <b>MM/DD/YY</b>
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<b>FOR MEDICAID USE</b>	Procedure(s) Authorized:	Quantity Authorized:
<input type="checkbox"/> Approved <div style="margin-left: 100px;">Grant Date</div> <div style="margin-left: 100px;">Expiration Date</div>		
<input type="checkbox"/> Modified — Reason:		
<input type="checkbox"/> Denied — Reason:		
<input type="checkbox"/> Returned — Reason:		
_____ SIGNATURE — Consultant / Analyst		_____ Date Signed