

Member Authorization Request Form

Please complete and fax this form to Network Health at 920-720-1916, email it to pophealthutiliza@networkhealth.com or mail it to Network Health, Attn: Utilization Management Department, 1570 Midway Pl., Menasha, WI 54952. For questions, please call 920-720-1602 or 866-709-0019.



Please include any clinical notes or office notes that would support the request, as well as CPT/HCPCS codes (if you have them) that will be billed for the services requested.

- Standard Request** (determination will be made no later than 14 calendar days after receipt of the request for an organization determination)
- Expedited Request** (waiting for a decision under the standard time frame could place the member's life, health or ability to regain maximum function in serious jeopardy)

Inpatient Request: Yes No

Form Filled Out By:		Contact Phone Number:	
Member Name:	Member ID #:	Date of Birth:	
Ordering Provider or Facility:			
Ordering Provider or Facility Phone #:		Ordering Provider or Facility Fax #:	
Rendering Provider or Facility:			
Rendering Provider or Facility Phone #:		Rendering Provider or Facility Fax #:	
Diagnosis (what condition you are being seen for):			
Requested Type of Service and CPT code(s) (Acupuncture, Genetic Testing, Procedure, Medication (dose and frequency)).			
Provider Requests an Authorization Start Date of:		End date:	
Indicate here if OK to withdraw the request if no authorization is required: <input type="checkbox"/> Yes <input type="checkbox"/> No			

Comments:

Complete the Additional Information for equipment or device Requests Only			
HCPCS Code of Item	Quantity	New	Replacement

Home Health Care Visits						
	Social Work	Registered Nurse	Occupational Therapy	Physical Therapy	Speech Therapy	Home Health Aid
Quantity						
CPT Code						

Behavioral Health Services (Please also fill out top portion of request form)						
Assessment Date:						
	Quantity	Outpatient	Intensive Outpatient (IOP)	Partial Hospital	Residential	Inpatient
Behavioral Health		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
AODA		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>