Population Health Authorization Request Form

Please complete and fax this form to Network Health at 920-720-1916 or attach to our provider authorization portal, iExchange or mail to Network Health, Attn: Utilization Management Department, 1570 Midway Pl., Menasha, WI 54952. For provider questions, please call 920-720-1602 or 866-709-0019.

*** If this is a request to extend services, please document the original authorization number.**

*** Must include any clinical notes or office notes that would support the request, as well as CPT/HCPCS codes that will be billed for the services requested. If this information is not provided, it could significantly delay the processing of the authorization.**

☐ **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)

Inspatient 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 NPI #:	
Rendering Provider or Facility **Phone #**:	Rendering Provider or Facility **Fax #**:	
ICD-10 Diagnosis Code(s):		
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:	New Episode of Care? ☐ Yes ☐ No
Number of Initial Sessions Requested:	If Applies, Number of Additional Sessions Requested:	
Indicate here if OK to withdraw the request if no authorization is required: ☐ Yes ☐ No		

Comments:

Complete the Additional Information for DME Requests Only						
HCPCS Code of Item	Retail Purchase Price	Quantity	Purchase	Rental	Repair	Replacement
	$					
	$					
	$					
	$					
	$					
	$					

Skilled Home Health Visits				
	SW	RN	ST	HHA
Quantity				
CPT Code				
Indicate here if OK to amend to MCG recommended number of visits for Home Health requests: ☐ Yes ☐ No				

Behavioral Health Services (Please also fill out top portion of request form with the required codes)						
Assessment Date:						
	Quantity	Outpatient	Intensive Outpatient (IOP)	Partial Hospital	Residential	Inpatient
Behavioral Health		☐	☐	☐	☐	☐
AODA		☐	☐	☐	☐	☐