Prior Authorization and Referral Request Form

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

https://nexaligniexchange.medecision.com/IEApp/login/providerLogin.faces

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

WPS HEALTH INSURANCE

WPS Employee Group Members:
WPS Health Plan-Attn: Integrated Care Management
P.O. Box 1229 ▪ Madison, WI 53701-1229
Phone: 800-977-7178 ▪ Fax: 608-226-8016

All other Members:
WPS Health Insurance-Attn: Integrated Care Management
P.O. Box 8190 ▪ Madison, WI 53708-8190
Phone: 800-333-5003 ▪ Fax: 608-226-4777

Date of Request
Start Date of Service

This request is for: ☐ Authorization ☐ Referral

MEMBER INFORMATION

First Name	Last Name	Date of Birth	Subscriber Number

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/HCPCS 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 WPS Health Plan at 800-333-5003. **A release of information form included in the application for insurance was signed by our member.**