WPS HEALTH INSURANCE

Outpatient Therapy Prior Authorization Request Form

Fax to Magellan Healthcare: **888-656-2204**

Questions? Please contact Magellan Healthcare Provider Services at 800-432-3640

Note: Prior authorization requests for therapies with an autism spectrum diagnosis (including OT/ST) should be submitted to the fax number on the Autism Spectrum Progress Report form. This form can be found at: wpsic.com/providers/files/ASD_Progress_Report.pdf

Request Date: _____ Number of Pages Faxed: _____

Patient Name: _____ Patient DOB: _____

Patient's WPS ID: _____

Servicing Facility/Clinic Name: _____ Participating: ◯ Y ◯ N

Facility/Clinic Billing Address: _____

Tax ID/NPI #: _____ Contact Name: _____

Contact Phone: _____ Provider Fax: _____

Type of Therapy: ◯ PT ◯ OT ◯ ST ◯ Chiro Retro: ◯ Y ◯ N

Description: _____

Diagnosis: _____ HCPC/CPT: _____

If retro, how many visits completed: _____

Date(s) of Service Requested: **From:** _____ (mm/dd/yy) **To:** _____ (mm/dd/yy)

Place of Service: ◯ Office (11)

◯ Outpatient Hospital (22)

◯ Home (12)

Please attach documentation to support the medical necessity for the services requested (i.e., initial therapy evaluation, any re-evaluations, and progress/daily notes).

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