# 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 anorganization 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:** ☐ **Yes** ☐ **No** | | |

**Comments**:

| **Complete the Additional Information for equipment or device Requests Only** | | | |
|---|---|---|---|
| HCPCS Code of Item | Quantity | New | Replacement |
| | | | |
| | | | |
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| **Home Health Care Visits** | | | | |
|---|---|---|---|---|
| | Social Work | Registered Nurse | 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 | | ☐ | ☐ | ☐ | ☐ | ☐ |
| AODA | | ☐ | ☐ | ☐ | ☐ | ☐ |