

# WPS REFERRAL AUTHORIZATION REQUEST

All referral requests are subject to medical review. Under the provisions of the Plan, the Plan Utilization Management Team or the Plan Medical Director must authorize services provided by non participating providers (also participating specialty providers for Prime Care) or services at non-participating locations to allow payment at the member's higher level of benefit.

Plan patients are responsible for payment of the portion(s) of the submitted charge(s) by the selected non-participating provider that in excess of the usual and customary fee. Authorization does not apply to the services or charges that are excluded by the Plan provisions.

**Attention:** Please fully complete form to avoid delays in processing.

Patient Name: _____		DOB: _____	
Member Name : _____		Customer Number: _____	
Patient Home Phone # (_____) _____			
Referral Request: URGENT _____ ROUTINE _____			
Referred To: _____			
Provider Name (last, first)		Specialty	
Street Address		Telephone Number	
City, State, Zip		Tax Identification Number	
Reason for referral : _____ Patient Preference _____ MD Preference _____ Services unavailable with participating providers			
_____ Other _____			
Patient Diagnosis / ICD9: _____			
CPT Code(s): _____			
Clinical history including pertinent diagnostic testing, prior treatment and rationale for referral request: _____			
_____			
_____			
Referral Requested For: _____ Consultation _____ Lab/X-ray/Testing _____ Treatment/Therapy _____ Surgery			
Dates of Service: _____ to _____		Number of Visits: _____	
Referred by: _____			
Print Physician's Name		Phone Number	Office Contact
Street Address		Fax Number	Office Contact Phone
City, State, Zip		Today's Date	

If you have any questions, please call WPS Health Insurance at **1-800-333-5003**

