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 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 is in excess of the usual and customary fee. Authorization does not apply to services or charges that are excluded by the Plan provisions.

Patient Name____ DOB ____

Member Name____ SS# of Member _______________________________

Patient Home Phone # (_________)__________________________

Referral Request: URGENT__________ ROUTINE__________

Referral requested to______________________________________ Specialty ___________________________________

Address ____

Phone number (_________)___________________________

Reason for referral: ❑ Patient Preference ❑ MD Preference ❑ Services unavailable with participating providers

❑ Other ____

Patient Diagnosis____

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Clinical history including pertinent diagnostic testing, prior treatment, and rationale for referral request. _______________

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Referral requested for (please indicate all services requesting):

❑ Consultation ❑ Lab/x-ray/testing ❑ Treatment/therapy ❑ Surgery

Dates of service of referral request ______________________ to _____________________

Number of services/visits requested________________________

Referred by____ Phone # (_____)____________ Fax #(_____)____________

Contact Person____ Today's Date__________________________

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

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