Bariatric and Transplant Surgery Prior Authorization Request Form

For PACE and Dual eligible FC Partnership Members ONLY

For Family Care (LTC) members call 1-866-937-2783 and ask to speak to the member's care team about authorization requirements. CCI UM does not review or authorize any services for the CCI Family Care (LTC) program.

Please complete this form and fax along with supporting clinical documentation to: Community Care Utilization Management Fax: 414-384-8272, phone: 262-207-9393, please call UM with any questions.

Incomplete forms or lack of supporting clinical may cause delay in determination or administrative denial for lack of clinical information.

Member Name:	D.O.B:	Medicare ID #: Medicaid ID #:
Member Phone:	Member Address:	
Requesting Provider Name/Clinic:		
Address:		
Clinical Contact/Title:	Phone Number:	Fax Number:
Servicing Provider Name/Clinic:		Tax ID:
Address:		
Clinical Contract/Title:	Phone Number:	Fax Number:

Request Type	
☐ Standard ☐ Expedited	Expedited is defined as: Care and services that provide the physician indicates or the HMO determines that following the ordinary time frame could jeopardize the member's health or ability to regain maximum function.
Please explain rationale for the urgency:	

Re uest Information				
Diagnosis or Symptom Information:			ICD-10:	
HCPC code:	Description:	Qty/Freq:	Start Date:	End Date:
HCPC code:	Description:	Qty/Freq:	Start Date:	End Date:

Privacy and confidentiality:

The information within this fax message is intended for the recipient(s) only. If you have received this fax in error, please contact us at 262-207-9393 (phone) or 414-384-8272 (fax) and destroy this document received. State and Federal Law prohibits any unauthorized use of this information. Thank you for your cooperation.

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Please Select One:	
☐	Anticipate Outpatient Service Only.
☐	Anticipate Observation stay for _____hours.
☐	Anticipate Inpatient Admission for _____days. Anticipated Date of Admission: Click or tap to enter a date.