# Bariatric and Transplant Surgery Prior Authorization Request

**For PACE and Partnership Members ONLY**

**Please complete the PA 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.:** | **Medicaid ID #:** |
| **Member Phone:** | **Member address:** | |
| **Requesting Provider Name/Clinic:** | | **Tax ID:** |
| **Address:** | | |
| **Clinical Contact/Title:** | **Phone Number:** | **Fax Number:** |
| **Servicing Provider Name/Clinic:** | | **Tax ID:** |
| **Address:** | | |
| **Clinical Contact/Title:** | **Phone Number:** | **Fax Number:** |

Request Type? Standard Expedited: Please explain rationale for urgency:
Expedited is defined as: Care and services that 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.

| | |
|---|---|
| **Diagnosis or symptom description:** | **ICD-10:** |

| | | | | |
|---|---|---|---|---|
| **CPT/HCPC code requested:** | **Description:** | **Quantity:** | Start Date: | End Date: |
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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:**

**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.**