



## Post Acute Facility 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:	DOB:	Medicaid #:
Member Phone:	Member Address:	

Current Setting/Hospital Stay
Location:
Admit Date:
Admitting Diagnosis:
Inpatient/Observation status:

Requesting/Serviceing Provider Information					
<input type="checkbox"/> IRF	<input type="checkbox"/> LTAC	<input type="checkbox"/> TBI	<input type="checkbox"/> SNF	<i>Are you requesting a Medicare Stay?</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
Requesting Facility Name: Address:				NPI:	
Contact at Facility	Name:	Phone:		Fax:	
ICD 10 Diagnosis Code & Description:					
Anticipated Admission Date:					
Estimated Subacute Length of Stay:					

Initial POC goals: including supporting clinical documentation. (Please attach)

**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.