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/Servicing Provider Information						
☐ IRF	☐ LTAC	☐ TBI	☐ SNF	*Are you requesting a Medicare Stay?*	☐ Yes	☐ 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)