SPECT/PET Imaging 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:**
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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:
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