# SPECT/PET Imaging Prior Authorization Request

**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 #:<br><br>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: | |

| **Request 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: |
| 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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| | | | | |
|---|---|---|---|---|
| HCPC code: | Description: | Qty/Freq: | Start Date: | End Date: |

| **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. |



205 Bishops Way, Brookfield, WI 53005 ● Phone: 262-207-9393 ● Fax: 414-384-8272