CHARTWELL Health Resources

PRIOR AUTHORIZATION REQUEST FORM

Vendor

Vendor name: Form completed by:

Vendor phone number: Vendor fax number:

Patient

Patient name: Date of birth:

Address:

Insurance

Primary insurance provider: Policy number:

Secondary or other insurance information:

Prescribing Physician

Prescribing physician name:

Phone number: Fax number:

Service

Diagnosis code (ICD-10):

Equipment/supply/service needed, including HCPCS codes:

Start of service: End date (if applicable):

Documentation

Valid and appropriate clinical documentation (e.g., medical visit notes, therapy logs, prescriptions) must be attached to complete the referral.

Return completed form to by fax to (608) 664-6193 OR by email to chrfax@chartwellwisc.com

2241 Pinehurst Drive, Middleton, Wisconsin 53562

608/831-8555 phone 608/664-6193 fax