1515 North Saint Joseph Avenue
P.O. Box 8000
Marshfield, WI 54449-8000

1-877-509-4979 | 605-910-6519
TTY 711 | Fax: 715-221-6616

Prior Authorization Request

Date ______________________________

Member information			
Member name (print)		SMID	Date of birth (m/d/y)
List the patient's diagnosis/condition			
Referring provider information			
Referring provider name (print)		Specialty	Telephone number
Referring provider address			
Contact person, if more information is needed	Title	Telephone number	Fax number
Rendering provider information ☐ Same as referring provider			
Rendering provider name (print)		Specialty	Telephone number
Rendering provider address			
Provider NPI		Provider tax ID	
Place of service			
☐ Ambulatory Surgery Center ☐ Hospital outpatient ☐ Hospital inpatient ☐ Provider's office ☐ Other ______________________			
Facility where services will be provided (include address if the provider provides services at more than one practice location)			
Service/Procedure information			
Scheduled date of service (m/d/y)	Requested service/procedure		
Procedure code(s)			
Diagnosis		Diagnosis code(s)	

Has the patient seen this provider in the past: ☐ Yes ☐ No

If yes, when ____

Has this patient received treatment for this condition from affiliated providers within Sanford Health Plan's network:

☐ Yes Indicate the providers who have seen this patient ____

____

☐ No Explain why an affiliated provider cannot provide the requested services ______________________

____

____

Provide supportive documentation for this prior authorization request.

____
Provider signature Date

Submit this completed form via:
Fax to 715-221-6616
If you have questions, contact Customer Service at 1-877-509-4979.