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

1-877-509-4979 | 715-221-9212
TTY 711 | Fax: 715-221-9215

Post Acute 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

☐ Long Term Acute Care (LTAC) ☐ Inpatient Rehabilitation (IPR) ☐ Swing Bed
☐ Skilled Nursing Facility (SNF) ☐ Other ______________________________

Facility where services will be provided (include address if the provider provides services at more than one practice location)

Provide supportive documentation for this prior authorization request.

______________________________ ______________
Provider signature Date

Submit this completed form via:

Fax to 715-221-9215

If you have questions, contact Post Acute Care Customer Service at 715-221-9212.