WEA Trust Pre-Authorization/Prior Authorization Request Form

Complete all Sections to ensure timely review

**Include all information listed on the "Services that need Medical Records Submitted" form on our website.*
Clinicals should be submitted with this request.
Fax to (608) 276-9119 or an Urgent Fax to (608) 661-6706

Provider appeals submitted on this form will not be considered. Please refer to the claim resubmission request form (CL6001-0217)

Section A: Request Information

Today's Date: _____

☐ Service is Scheduled *(only if applicable)* Schedule Date: _____

For non-urgent preservice decisions, the organization makes decisions within 15 calendar days of receipt of the request.

☐ Urgent Request *(only if applicable)* Reason for Urgency: _____

For urgent preservice decisions, the organization makes decisions within 72 hours of receipt of the request.

According to ERISA, urgent is defined as "any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations: *1. Could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function or; 2. In the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care of treatment that is the subject of the claim".*

Inpatient Admission: ☐ New Admission ☐ Concurrent Admission

☐ Retro Request *(Retro request refers to services already rendered and denied as member liability)*

For postservice decisions, the organization makes decisions within 30 calendar days of receipt of the request.

Section B: Type of Request (*check appropriate box)*

☐ Medical/Surgical ☐ TMJ/Oral Splints/Oral Surgery ☐ DME (include cost of item)

☐ Home Health ☐ Genetic Testing

☐ CPAP Rental Date of Sleep Study: _____ AHI/RDI _____

☐ CPAP Replacement Original Purchase Date: _____

Why replacement is needed: _____

☐ Advanced Imaging of Neck and Spine ☐ Advanced Imaging (MRA and PET Scan)

☐ Advanced Imaging (All advanced imaging scans require preauthorization for State Health Plan members)

Section C: Member Information

Member Last Name: _____ Member First Name: _____ M. I. ___

Subscriber Number: _____ Date of Birth: _____

Section D: Service Information

Description of Service: _____

Diagnosis Code: _____ Procedure Code (CPT/MCPCS): _____

Service Start Date: _____ Service Frequency: _____

Section E: Facility and Servicing Provider Information

Facility Name: _____ Servicing Provider: _____

Location: _____ Location: _____

NPI (Required): _____ Completed by: _____

Phone: _____ Phone: _____

Fax: _____ Fax: _____

NOTE: *A release of information form included in the application for insurance was signed by our member.*

Please note that the preauthorization of any procedure does not guarantee benefits or payment. Approval is based on medical necessity as defined in the patient's benefit plan or certificate. All benefits are subject to the term, conditions and exclusions of the benefit plan or certificate. This may include policy language regarding pre-existing conditions or signed affidavits stating that the insurance bears no responsibility, as signed by the insured. Policy exclusions for certain types of services may also apply. For additional benefit information, please contact WEA Trust at 1-800-279-4090.