Prior Approval Request Form

Member Name:	Provider:
Member Number:	Provider Fax #:
Date of Birth:	Provider Phone #: Contact Name:
Ordering Physician:	Place of Service/Treatment and Address:
Physician's Address:	
Service Requested:	
Starting and Ending Dates of Service:	Frequency of Service:
Diagnosis/ICD-9 code:	Procedure/CPT-4 code(s):

Is this related to an injury? ❑ Yes ❑ No
Date of Injury____________________

Is this Workers' Compensation related? ❑ Yes ❑ No
Date of Injury ____________________

Provided all necessary documentation is received we will complete the review in 15 days or less. If the requested information is incomplete or additional information is needed, this timeframe may be extended.

Expedited/urgent prior approvals will be completed within 72 hours or less once all necessary information is received. **According to the HIRSP Policy, emergency is defined as "a medical condition that manifests itself by acute symptoms of sufficient severity, including severe pain. The condition must be severe enough to lead a prudent layperson, who possesses an average knowledge of health and medicine, to reasonably conclude that a lack of immediate medical attention will likely result in any of the following:**

1. *Serious jeopardy to the person's health or, with respect to a pregnant woman, serious jeopardy to the health of the woman or her fetus;*
2. *Serious impairment to the person's bodily functions;*
3. *Serious dysfunction of one or more of the person's body organs or parts.*

Please note that the prior approval 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 terms, 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 HIRSP at 1-800-828-4777.**

HIRSP Care Management
FAX: 608-226-4777
Attn: Prior Approval

Information to Include When Requesting Prior Approval:

Medical/Surgical

1. Clinical notes related to diagnosis or procedure including any conservative medical management.
2. Any imaging reports to support the need for treatment.

DME/Prosthetic Exceeding $1,500

1. DME HCPCS code(s) & fees (rental versus purchase).
2. Supporting medical notes & related test results.
3. Name & Tax ID # of DME provider.
4. MD prescription for DME.

Therapies

1. Most recent evaluation and treatment plan plus 3 months previous therapy notes.
2. Type of modalities.
3. MD prescription for service.
4. Name and Tax ID of Therapist.

Medical/Dental

1. ADA codes & fees.
2. X-rays.
3. Date of service for procedure.
4. Clinical notes related to diagnosis or procedure including any conservative medical management.
5. If this is a dental injury, include the date of injury to tooth or mouth and also a description of how the injury occurred.

HIRSP AUTHORITY
1751 W. Broadway, P.O. Box 8961
Madison WI 53708-8961
www.hirsp.org

© 2009 Wisconsin Physicians Service Insurance Corporation. All rights reserved. 24228-002-0909