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 1-877-492-5189 | 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			
<input type="checkbox"/> Same as referring provider			
Rendering provider name (print)		Specialty	Telephone number
Rendering provider address			
Provider NPI		Provider tax ID	
Place of service			
<input type="checkbox"/> Long Term Acute Care (LTAC) <input type="checkbox"/> Inpatient Rehabilitation (IPR) <input type="checkbox"/> Swing Bed <input type="checkbox"/> Skilled Nursing Facility (SNF) <input type="checkbox"/> 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.