

**Incomplete/ illegible information will  
BE RETURNED AND NOT  
PROCESSED**

## Health Tradition

P.O. Box 188  
La Crosse, WI 54602-0188  
Telephone: 608-781-2118  
Toll-Free: 1-888-758-7848  
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### External Referral Request

**Health Tradition Health Plan requires prior authorization and approval for covered services by the plan before services are received by a member from an out-of-network provider. This also includes Network Rental patients who are requesting in-network level benefits.**

**Mayo Clinic is considered an out-of-network provider.**

First Name: _____	M.I. _____	Last Name: _____	DOB: _____
Address: _____			
street	city	state	zip
<input type="checkbox"/> Premier	<input type="checkbox"/> Premier Plus	<input type="checkbox"/> BadgerCare Standard	<input type="checkbox"/> BC Benchmark <input type="checkbox"/> 65+
<input type="checkbox"/> Network Rental (indicate coverage group) _____		Subscriber Name _____	
Insurance Number: _____		<i>Required-Obtain from Registration if necessary</i>	

**Diagnosis:** \_\_\_\_\_

Patient is being referred for consultation to: \_\_\_\_\_

(Include name of practitioner, facility, specialty and location)

Indicate why patient needs cannot be met at Luther Midelfort or at any other in-network facility:

List date(s) and name(s) of specialist(s) that have previously evaluated patient for this diagnosis/condition:

**All applicable tests, radiology services, diagnostic outpatient testing and outpatient procedures are expected to be done in-network prior to this consultation visit. Please provide patient or consulting physician with all pertinent testing results to bring to this consultation visit.**

List all applicable tests, radiology services, diagnostic outpatient testing and outpatient procedures that cannot be done in-network:

PRINT Provider : _____	Date: _____
PRINT Name of person completing: _____	

Approval  Denial  Partial Approval/Partial Denial  Pending

Date: \_\_\_\_\_ Signature: \_\_\_\_\_