

**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
Fax: 608-781-9654

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 Franciscan Skemp Healthcare 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: _____