



# **Prior Authorization Request for Out-of-Network Outpatient Mental Health and Chemical Dependency Services**

Prior authorization is required for any out-of-network outpatient mental health/chemical dependency services. Failure to submit the completed form to Health Tradition Health Plan may result in denial of services.

1. Complete all sections of the form. Failure to provide the requested information will delay the processing of your request. Any incomplete or illegible forms will be returned. If more space is needed, you may attach additional documentation to this form.
2. Fax the completed form to the Utilization Management Department at **608-781-9654**.
3. After the Health Plan receives the request, reviews all necessary information, and determines medical necessity, a decision letter will be sent to the member and the requesting provider.

**Please note: Any further out-of-network services, such as psychological testing, group therapy, day treatment, structured outpatient programs, transitional care, and/or inpatient treatment require separate/additional prior authorization.**

**To verify member's eligibility, please contact:  
1-877-832-1823 – Premier, Premier Plus, 65Plus Plans  
1-800-545-8499 - BadgerCare Plus Plans**



Please complete form and fax to:  
Health Tradition Health Plan UM Department  
Fax Number: 608-781-9654

**Prior Authorization Request for Out-of-Network  
Outpatient Mental Health and Chemical Dependency Services**

Please **print** clearly. Inability to read this form may delay processing.  
Completion of this form does not imply authorization of care or provision of plan benefits.

Date \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Insurance Number: \_\_\_\_\_

Select Plan: Premier Premier Plus 65Plus BadgerCare Plus

Name of Referring Provider: \_\_\_\_\_

Referred to Provider Name: \_\_\_\_\_

Clinic Name and Address: \_\_\_\_\_  
\_\_\_\_\_

Telephone Number: \_\_\_\_\_

Type of service being requested (select one only):

- Individual/Family counseling sessions
- Group therapy sessions
- Day Treatment
- Transitional
- Psychological testing (Must complete the form titled "Prior Authorization for Psychological Testing")

Name of Person Completing Form: \_\_\_\_\_

Phone#: \_\_\_\_\_

DSM-IV Diagnosis (may attach treatment plan):

Axis I \_\_\_\_\_ Axis II \_\_\_\_\_ Axis III \_\_\_\_\_

Axis IV \_\_\_\_\_ Axis V Current \_\_\_\_\_

Highest in the Past Year \_\_\_\_\_

**Medication List**

None

Name	Date Started	Prescribing Practitioner

Describe current symptoms:

**Treatment Goals (May attach a copy of the Treatment Plan)**

Indicate treatment goals or progress towards previous goals, including improvements in symptoms and effectiveness of current treatment.

If there has been no progress, what are the barriers and the plan to address these?

List previous dates of service (mm/dd/yy): \_\_\_\_\_

Anticipated length of treatment: \_\_\_\_\_