# Referral Authorization Form

**PRIOR AUTHORIZATION IS REQUIRED FOR SERVICES BY ANY NON-PARTICIPATING PROVIDER.** Payment is authorized only for the medical services noted below, and is subject to the limitations and exclusions as outlined in the Senior Preferred (HMO) Evidence of Coverage.

**Mail to:** Senior Preferred, ATTN: Medical Management, 840 Carolina Street, Sauk City, WI 53583
**Phone:** (800) 394-5566 | Fax: (608) 881-8397

## Patient Data

Patient's Name: Date of Birth: Clinic #:

Patient's Address: City: State: ZIP Code:

Primary / Other Diagnosis:

Referred to (Provider Name): Specialty:

Facility Name and Address: Phone:

## For Provider Completion

**SERVICES REQUESTED BY PROVIDER:**

- ☐ CONSULT – **INCLUDING** Lab / X-ray
- ☐ CONSULT **ONLY** – Lab / X-ray to be done at Senior Preferred Network Provider
- ☐ TREATMENT
- ☐ OTHER DIAGNOSTIC TESTING
- ☐ INPATIENT HOSPITALIZATION (Senior Preferred MUST BE NOTIFIED at time of admission)
- ☐ PROCEDURE

**REASON:**

- ☐ Services not available in network
- ☐ Second Opinion – Patient Requested
- ☐ # Visits Requested ____________________
- ☐ Second Opinion – Provider Requested
- ☐ Outreach
- ☐ Other, Explain ________________________________________

________________________________________________________

________________________________________________________

Referring Provider's Name: **PLEASE PRINT** Referring Provider's Signature / Date

Please indicate on line below whom should be contacted and preferred contact information for decision:

________________________________________________________

☐ **REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that applying the standard time for making a determination could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.**

Provider Signature Date

**THIS REFERRAL IS NOT VALID WITHOUT AN APPROVAL LETTER / NOTIFICATION FROM SENIOR PREFERRED**

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