Quartz Medicare Advantage and DSNP prior authorization request form

Prior authorization is required for services by any out-of-network provider. Payment by Quartz is authorized only for the medical services noted below and is subject to the limitations and exclusions outlined in the Quartz Medicare Advantage (HMO)/DSNP Evidence of Coverage, found at QuartzBenefits.com/DocumentLookup.

Mail or fax the completed form to:
Attn: Medical Management
Quartz Medicare Advantage
2650 Novation Parkway • Fitchburg, WI 53713
(800) 897-1923 (TTY: 711) • Fax (608) 881-8397

Date requested
______/_____/_____

Patient information

Patient name:	Date of birth:	Member number:	Date of service:

Referral information

From

Referred from:	☐ Patient's request
Clinic contact:	Phone number:
Site/location:	Fax:

To

Referred to:	
Clinic contact:	Phone number:
Site/location:	Fax:

Services requested

☐ Consult only ☐ Follow-up ☐ DME ☐ Lab ☐ X-ray ☐ Home care ☐ Therapy _____ST _____PT _____OT

☐ Surgery ______Inpatient ______Outpatient Description:

Primary diagnosis code:	Description:
CPT/HCPCS code(s):	Description:

Comments (indications for referral to a specialist and/or reason for out-of-network request):

Note: This referral does not guarantee payment for services. Benefits will be determined in accordance with the policy terms in effect on the date of service. Please refer to your patient's Evidence of Coverage for a complete description of plan benefits, limitations, and exclusions.

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 patient or the patient's ability to regain maximum function.

Provider signature:____ Date:__________________

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