CHARTWELL
Health Resources

PRIOR AUTHORIZATION REQUEST FORM

Provider

Provider name: _____ Contact person: _____

Phone number: _____ Fax number: _____

Patient

Patient name: _____ Male ☐ Female ☐

Date of birth: _____ Phone number: _____

Address: _____

Physician

Prescribing physician: _____ NPI #: _____

Phone number: _____ Fax number: _____

Service

Diagnosis code (ICD-10): _____

Service/equipment needed, including HCPCS codes: _____

Start of service: _____ End date (if applicable): _____

Insurance

Primary insurance provider: _____ Policy number: _____

Group #: _____ Effective date: _____

Secondary or other insurance information: _____

Documentation

A valid prescription and supporting clinical documentation must be attached to complete the referral.

Valid prescription: ☐ Clinical documentation: ☐

Please fax completed form to Chartwell Health Resources at (608) 664-6193

2241 Pinehurst Drive, Middleton, Wisconsin 53562

608/831-8555 phone 608/664-6193 fax