



1-800-482-8010 (Phone) 608-836-6516 (Fax)

**Out of Network Referral/Authorization Request Form**

(Requests to non-plan providers must be approved by the UM Department prior to obtaining services)

Authorization Number

Date: \_\_\_\_\_  
PLAN: CCHP Dean Southeast

Patient Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_

DOB: \_\_\_\_\_  
   
Telephone # \_\_\_\_\_  
Member #: \_\_\_\_\_

Referring Physician: \_\_\_\_\_  
Address \_\_\_\_\_  
\_\_\_\_\_

Physician Signature Required  
Provider #:  
Telephone #:  
Fax #:

Referred To Provider: \_\_\_\_\_  
Address \_\_\_\_\_  
\_\_\_\_\_

Specialty:  
Provider #:  
Telephone #:  
Fax #:

**If referring to a non-plan provider – The following information must be provided:  
Reason care cannot be provided in plan or a list of plan provider(s) a member has already seen.  
Or check if this is a patient request**

Diagnosis: \_\_\_\_\_ Dx code (required) : \_\_\_\_\_

Number of visits \_\_\_\_\_ Duration: \_\_\_\_\_ From \_\_\_\_\_ To \_\_\_\_\_

Service Requested/Reason for Non Plan Provider Request : \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If referring to a non-plan provider – list plan specialist seen:

- **Approved request does not authorize payment of non-covered or exhausted benefits**
- **If you have questions you can contact Customer Service Department at 800-482-8010.**

HEALTH PLAN USE ONLY			
<input type="checkbox"/> Approved	<input type="checkbox"/> Approved with Modification	<input type="checkbox"/> Denied	<input type="checkbox"/> Written Treatment Plan Required
Processed by: _____		Date: _____	
Comments: _____ _____ _____			
Service Class:	Hold Code:	Place of Service:	Auth: _____ Type: _____ Payment Level: _____