Prior Authorization (PA) Request Form

Submit the prior authorization request form along with supporting documentation to WPS Government Health Administrators (GHA).

WPS J5	WPS J5 National	WPS J8
Fax: (608) 223-7553	Fax: (608) 223-7553	Fax: (608) 224-3508

Date of Submission: _____

Type of Prior Authorization Request

- ☐ Blepharoplasty
- ☐ Botulinum toxin injection
- ☐ Cervical Fusion w/ Disc Removal
- ☐ Implanted Spinal Neurostimulators
- ☐ Panniculectomy
- ☐ Rhinoplasty
- ☐ Vein ablation

Initial Request: ◯ Subsequent/Resubmission Request: ◯

Unique Tracking Number (UTN), if known: _____

Expedited Request: Yes ◯ No ◯

Expedited Request Reason: _____

Retroactive Request: Yes ◯ No ◯

Note: Requests to backdate a prior authorization will not be honored when the initial prior authorization was submitted after services were rendered to the beneficiary.

Facility Information

Facility Name: _____

Facility PTAN: _____ Facility NPI: _____

Facility Address 1: _____

Facility Address 2: _____

City: _____ State _____ Zip Code _____

Physician/Practitioner Information

Physician/Practitioner's Name: _____

Physician/Practitioner's PTAN: _____ Physician/Practitioner's NPI: _____

Address 1: _____

Address 2: _____

City: _____ State _____ Zip Code _____

Beneficiary Information

Medicare Beneficiary Identifier (MBI): _____

Date of Birth: _____ Gender: _____

Beneficiary First and Last Name: _____

Requestor Information

Requester's Name: _____

Requester's Title: _____

Requester's Email Address: _____

Phone Number: _____ Fax Number: _____

Service Specific Information

Anticipated Date of Service: _____ Type of Bill: _____

HCPCS/CPT Code & Modifier: _____

Units of Service_____

Additional Information (e.g. vein location):

Service Specific Information

Anticipated Date of Service: _____ Type of Bill: _____

HCPCS/CPT Code & Modifier: _____

Units of Service_____

Additional Information (e.g. vein location):