SecurityHealth Plan℠

Promises kept, plain and simple.®

1515 North Saint Joseph Avenue
PO Box 8000
Marshfield, WI 54449-8000

1.800.472.2363 | 715.221.9555
TTY: 711
Health Services fax: 715.221.6616

Nonaffiliated Provider Services

Prior Authorization Request

Date _____

Member information			
Member name (print		SMID	Date of birth (m/d/y)
List the patient's diagnosis/condition			
Referring provider information			
Referring provider name (print)		Specialty	Telephone number
Referring provider's address			
Contact person, if more information is needed	Title	Telephone number	Fax number

1. Who is the provider the patient being referred to _____
2. What is this provider's specialty _____
3. Where will the services be provided *(indicate name of practice and location)* _____

   _____
4. Has the patient seen this provider in the past: ☐ Yes ☐ No

   If yes, when _____
5. Is an appointment scheduled: ☐ Yes ☐ No If yes, when _____
6. What are the specific services being requested:

   ☐ Office visit/second opinion ☐ Ancillary service ☐ Procedure ☐ Other _____

   Note: Security Health Plan network providers should be used for second and third opinions in all but unusual circumstances. If the services are available within the network, a clear explanation of why the in-network service cannot be used must be provided in #9 below. If a procedure that adequately addresses the patient's condition is available within the network, a referral outside the network is likely to be determined as not medically necessary by Security Health Plan.
7. List the applicable CPT/ICD codes _____
8. Has this patient received treatment for this condition from affiliated providers within Security Health Plan's network: ☐ Yes ☐ No

   If yes, indicate the providers who have seen this patient _____

   _____
9. Explain why an affiliated provider cannot provide the requested services _____

   _____

   _____

Provide any supportive documentation as appropriate for this referral.

Provider signature _____ Date _____

Mail or fax form to: Security Health Plan
Health Services Department
PO Box 8000
Marshfield, WI 54449-8000
Fax 715-221-6616

Marshfield Clinic providers route to:
Health Services Department
Routing location, SHP

