



Choose One	<input type="checkbox"/> Mental Health	<input type="checkbox"/> AODA (Substance)
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Choose One:	Detox	IP	Residential	PHP	Day TX	IOP	OP Out of Network	In-Home
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- Pre-Service Non-Urgent/Standard (Physician Signature NOT Required)**
 - Pre-Service Administratively Urgent (Physician Signature NOT Required)**
(Services which do not meet the definition of Medically Urgent, however, are deemed to be time sensitive by one or more of the affected parties.)
 - Pre-Service Medically Urgent/Expedited (Attending Physician Signature REQUIRED Below unless a Medicare Advantage member)**
(Medically Urgent—In the opinion of the attending physician, there is a risk to the member’s life, serious bodily injury or pain that cannot otherwise be managed. Physician signature NOT required for Medicare Advantage requests.)
- Attending Physician Signature:** _____ **Date:** _____

PATIENT DEMOGRAPHICS		
Patient Name:	Date of Birth:	
Member ID:	Phone Number:	
Street Address:		
City:	State:	Zip Code:

REFERRING PROVIDER INFORMATION		
Provider Name:	Phone #:	
Street Address:	Fax #:	
City:	State:	Zip Code:
Provider #:	Specialty:	

REFERRED TO PHYSICIAN/FACILITY/PROVIDER INFORMATION		
Referred To:	Phone #	
Street Address:	Fax #	
City:	State:	Zip Code:
Specialty:		

REQUEST INFORMATION	***PLEASE INCLUDE H&P WITH ALL AVAILABLE DOCUMENTATION***
Date(s) of Service:	# of Visits:
CPT Code(s) and Description:	
ICD 10 Diagnosis Code(s) and Description:	

Additional Information:

Form Submitted By:		
Name:	Phone:	Fax:

The completed form can be faxed to: 608-252-0830
 If you have any questions regarding the services or form, please contact our Customer Care Center at 866-514-4194 or review wellfirstbenefits.com. Requests to non-plan providers must be approved prior to obtaining services.
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