WellFirst Health®
provided by SSM Health Plan

Outpatient Services Authorization Form
Fax completed form to: 608-252-0863

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		
Date (s) of Service:	Diagnosis Code(s):	ICD 10 Code(s):
CPT Codes and Description:		
# of Visits	3rd party liability: ☐ W/C ☐ MVA ☐ Other	

Additional Information:

Form Submitted By:		
Name:	Phone:	Fax:

The completed form can be faxed to: 608-252-0863
If you have any questions regarding the services or form, please contact our Customer Care Center at 866-514-4194 or visit wellfirstbenefits.com
An approved prior authorization is required before obtaining services from non-plan providers.