my Advocate
MEDICARE ADVANTAGE

1515 North Saint Joseph Avenue
P.O. Box 8000
Marshfield, WI 54449-8000

1.800.472.2363 | 715.221.9555
TTY 711
Fax: 715.221.9215

Post Acute Prior Authorization Request

Date _____

Member information

Member name (print)	SHP ID	Date of birth (m/d/y)

List the patient's diagnosis/condition

Referring provider information

Referring provider name (print)	Specialty	Telephone number

Referring provider address

Contact person, if more information is needed	Title	Telephone number	Fax number

Rendering provider information

☐ Same as referring provider

Rendering provider name (print)	Specialty	Telephone number

Rendering provider address

Provider NPI	Provider tax ID

Place of service

☐ Long Term Acute Care (LTAC) ☐ Inpatient Rehabilitation (IPR) ☐ Swing Bed
☐ Skilled Nursing Facility (SNF) ☐ Other _____

Facility where services will be provided (include address if the provider provides services at more than one practice location)

Provide supportive documentation for this prior authorization request.

_____ _____
Provider signature Date

Submit this completed form via:

- Fax to 715.221.9215

If you have questions, contact Post Acute Care Customer Service at 715-221-9212.