

UNIVERSITY OF WISCONSIN BEHAVIORAL HEALTH  
AUTHORIZATION ADDITION/EXTENSION REQUEST FORM

UWBH Fax #: 608-238-1026

UWBH E-mail address: \_\_\_\_\_

Today's Date: \_\_\_\_\_

UNITY

PPIC

Requestor's Name: \_\_\_\_\_ Member Name: \_\_\_\_\_

Requestor's Phone: \_\_\_\_\_ Member Number: \_\_\_\_\_

Requestor's/Clinic fax: \_\_\_\_\_ Member DOB: \_\_\_\_\_

Clinic Name: \_\_\_\_\_ Authorization Number: \_\_\_\_\_

Provider Name: \_\_\_\_\_ End Date of Authorization: \_\_\_\_\_

Provider ID Number: \_\_\_\_\_ Number of Visits Remaining: \_\_\_\_\_

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**REQUESTING:** (subject to approval by UWBH)

DX Change – Axis I \_\_\_\_\_  Date Extension to: \_\_\_\_\_

Denied Claim Requesting Reprocess  Provider Name Change to: \_\_\_\_\_

Insurance Change To:  Unity  PPIC

New Policy # \_\_\_\_\_ Sessions Remaining \_\_\_\_\_ Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_

New Auth # (UWBH to complete) \_\_\_\_\_

Reason for Request: \_\_\_\_\_

Are you requesting extension due to Denied Claims?  Yes  No

If yes, clearly list all dates of service denied: \_\_\_\_\_

Claim Numbers: \_\_\_\_\_

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**UWBH USE ONLY**

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Consultant Comments: \_\_\_\_\_

# Visits to Add to Current Auth: \_\_\_\_\_

APPROVED as requested  APPROVED as noted  Denied

Consultant: \_\_\_\_\_ Date: \_\_\_\_\_

Administrative Staff: \_\_\_\_\_ Date Entered: \_\_\_\_\_