

**NOTE:**  
Authorizations are generally limited to the enrolled youth.

WRAPAROUND MILWAUKEE  
**OUT OF NETWORK VENDOR  
AUTHORIZATION EXTENSION FORM**



**FORM MUST BE COMPLETED/SUBMITTED WITHIN 14 DAYS OF CURRENT AUTHORIZATION END DATE**

Care Coordinator Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Care Coordinator Agency: \_\_\_\_\_

Client Name: \_\_\_\_\_  Wraparound  REACH (**check program**)

End Date of Current Authorization: \_\_\_\_\_ Proposed End Date of Service: \_\_\_\_\_

Reason for Extension: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Approved by Child/Family Team?  Yes  No Included in POC?  Yes  No Date of POC \_\_\_\_\_

**AGENCY INFORMATION**

Agency Name: \_\_\_\_\_ Tax ID #: \_\_\_\_\_

Address: \_\_\_\_\_

Street

City

State

Zip

Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_ FAX: \_\_\_\_\_

**SERVICES / DIRECT SERVICE PROVIDER**

Service Code	Service Name	Rate	Provider Name

Submitted By:

\_\_\_\_\_  
Care Coordinator Signature

\_\_\_\_\_  
Date

Supervisor Review/Approval:

\_\_\_\_\_  
Care Coordinator Supervisor Signature

\_\_\_\_\_  
Date

**PROVIDER NETWORK PROCESSING**

Out-of-Network Referrals are processed within 48 hours of receipt. **Care Coordinator and Provider will be notified of the outcome of the extension request.**

**PROVIDER NETWORK ACTION**

PENDING  APPROVED  DENIED

**COMMENTS:** \_\_\_\_\_

\_\_\_\_\_

Approved By:

Provider Network Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Return completed form to Theresa Randall, Wraparound Milwaukee – Provider Network – FAX 414-257-7575  
9201 Watertown Plank Road, Milwaukee, WI. 53226 / Telephone Number 414-257-8108**