

NOTE:
Authorizations are generally limited to the enrolled youth.

WRAPAROUND MILWAUKEE
**OUT OF NETWORK VENDOR
REQUEST FORM**



COMPLETE A SEPARATE FORM FOR EACH OUT-OF-NETWORK AGENCY WORKING WITH THE YOUTH
ATTACH A COPY OF THE WRAPAROUND REFERRAL FORM FOR THE REQUESTED SERVICES

INCOMPLETE REQUESTS AND REQUESTS THAT ARE MORE THAN 30 DAYS OLD WILL NOT BE PROCESSED.

Care Coordinator Name: _____ Phone: _____

Care Coordinator Agency: _____

Client Name: _____ Wraparound REACH (*check program*)

Anticipated First Date of Service: _____ Anticipated Last Date of Service: _____

(Approvals are limited to a maximum of 6 months and can be renewed if needed)

Justification for Use of Out of Network Provider/Agency: _____

Describe Efforts to Identify In-Network Agency/Provider: _____

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: _____

SERVICE(S) / DIRECT SERVICE PROVIDER(S)

Service Code	# of First Month Units	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 Requests are processed within 48 hours of receipt. Following administrative approval and verification of Provider credentials/licensing. Timeframe for Out-of-Network Agency compliance with this requirement varies.

Care Coordinator and Provider will be notified of the outcome of the request.

PROVIDER NETWORK ACTION

PENDING APPROVED DENIED

COMMENTS: _____

Provider Network Signature: _____ Date: _____

**Return completed form, along with provider referral, to Theresa Randall, Wraparound Milwaukee Provider Network
FAX: 414-257-7575 / PHONE: 414-257-8108**