Children's Community Health Plan™
A member of Children's Hospital and Health System.

Dean HEALTH PLAN

1-800-482-8010 (Phone) 608-836-6516 (Fax)

Out of Network Referral/Authorization Request Form

(Requests to non-plan providers must be approved
by the UM Department prior to obtaining services)

Authorization Number

Date:_____

PLAN: ☐ **CCHP**   ☐ **Dean Southeast**

Patient Name: _____
Address: _____
_____

DOB:_____

Telephone # _____

Member #:_____

Referring Physician: _____
Address _____
_____
_____

_____
Physician Signature Required

Provider #:

Telephone #:

Fax #:

Referred To Provider:_____
Address _____
_____
_____

Specialty:

Provider #:

Telephone #:

Fax #:

Is this related to a third party liability? ☐ W/C ☐ MVA ☐ Other

Diagnosis: _____   Dx code (*required*) : _____

Number of visits _____   Duration:_____ _____
                                          From   To

Service Requested: _____
_____
_____
_____

If referring to a non-plan provider – list plan specialist seen:
▪ **Approved request does not authorize payment of non-covered or exhausted benefits**
▪ **If you have questions you can contact Customer Service Department at 800-482-8010.**

HEALTH PLAN USE ONLY			

☐ Approved   ☐ Approved with Modification   ☐ Denied   ☐ Written Treatment Plan Required
Processed by: _____   Date: _____
Comments:_____
_____
_____

Auth: _____
Type: _____
Service Class: Hold Code: Place of Service: Payment Level: