



# Service/Procedure Prior Authorization Request

Date of Request:

Member Information		
Member Name (please print)	Date of Birth	Member ID

Provider Information		
Prescribing Provider	Tax ID	Fax#
Place of Service	Tax ID	NPI
Diagnosis	ICD-10	
Procedure(s)/Service(s)	CPT Code(s)	
Date of Service	Request Date	
Place of Service (Please select one): Hospital Outpatient                      Inpatient, _____ days                      ASC Observation, _____ hours                      Office                      Home		
Provider Contact Name	Phone	Fax

Please submit clinical documentation to support medical necessity for requested item.

Please indicate if any of the following apply:			
<input type="checkbox"/> MVA	<input type="checkbox"/> Liability	<input type="checkbox"/> Worker's Compensation	<input type="checkbox"/> Indicate if this is an urgent request

Please refer to the [prior authorization guidelines](#) located at group-health.com for a list of services that require prior authorization.

**Privacy and Confidentiality:** The information within this fax message is intended for the recipient(s) only. If you have received this fax in error, please contact us at (715) 552-4300 and destroy this document received. State and Federal Law prohibits any unauthorized use of this information. Thank you for your cooperation.

**Please fax completed form to:** Group Health Cooperative of Eau Claire **Fax:** 715.552.7202