group health Cooperative of eau claire

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:			
☐ MVA	☐ Liability	☐ Worker's Compensation	☐ 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.

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