



# Service/Procedure Prior Authorization Request

## Member Information

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

Requesting Practitioner	Practitioner Tax ID	Practitioner NPI
Facility (where performed)	Facility Tax ID	Facility NPI
Facility Address		
Diagnosis		ICD-10
Procedure(s)/Service(s)	CPT Code(s)	
Date of Service (if not scheduled, use TBD)		
Place of Service (Please select one): Hospital Outpatient      Inpatient, _____ days      ASC Observation              Office    Home		
UM Contact Name	UM Phone	UM 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

**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 715.552.4333 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