group health Cooperative of eau claire

Authorization Request Form

Behavioral Health Inpatient Admission

Patient's Name: _____ DOB: __/__/__ ID# _____

***Attach H&P and clinical information including medications and fax all to (715) 852-5755.**

Note: Discharge summary including follow up care information is required at time of discharge.

Diagnosis Code(s):

_____

_____

_____

Type of Admission

☐ Chapter 51/Emergency Detention

☐ Mental Health

☐ Detox

Date of Admission __/__/__ Estimated Length of Stay: _____ Actual D/C Date: __/__/__

Brief Summary of Current Clinical Status/Admission Information:

_____

_____

_____

Provider Name: _____

Facility Name: _____ NPI: _____

Address: _____ Tax ID: _____

Contact Name: _____ Phone: _____ Fax: _____

The submission of supporting clinical documentation/plan of care is required with this form.

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.