



Intensive Outpatient Treatment Prior Authorization Request

Member Information			
Member Name (please print)		Date of Birth	Member ID
<p><i>Intensive in home therapy requires that a health check screening has been completed within the past 12 months. Intensive outpatient and Intensive in home levels of care require authorization prior to initiating services.</i></p>			
Diagnosis	ICD-10	Patient Regularly Participates <input type="checkbox"/> Yes <input type="checkbox"/> No	Request Date
Number of Visits this Calendar Year		Anticipated Discharge Date	Start Date
Type of Service: <input type="checkbox"/> Mental Health <input type="checkbox"/> AODA			
<input type="checkbox"/> Intensive Hours/week _____ (9-12 hours/week) <input type="checkbox"/> Intensive In-home Hours/week _____ (4-8 hours/week)			
Brief Summary of Current Clinical Status			
Criteria for Termination			

Provider Information		
Provider	Facility Name	NPI
Address		Tax ID
Contact Name	Phone	Fax
Please submit clinical documentation to support medical necessity for requested item.		

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 or 715.852.5755