



Inpatient Admission Prior Authorization and Notification

Member Information

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

Admitting Provider		NPI
Facility	Tax ID	NPI
Procedure		CPT Code
Admitting Diagnosis		ICD-10
Admission Date	Admission Status <input type="checkbox"/> Inpatient <input type="checkbox"/> Observation	
Facility Contact Name	Phone	Fax

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

Newborn Information (If applicable)

Date of Birth	Birth Weight	Gender (check one) <input type="checkbox"/> Male <input type="checkbox"/> Female
Full Name (if available)		

Please indicate if any of the following apply:

MVA Liability Worker's Compensation

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Please fax completed form to: Group Health Cooperative of Eau Claire **Fax:** 715.852.5755