



PT/OT/ST Prior Authorization Request

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

Provider Information		
Requesting Provider		
Facility	Tax ID	NPI
Service PT OT ST	CPT Code	
Diagnosis		ICD-10
Start Date	Frequency of Visits	Number of Visits Requested
Provider Contact Name	Phone	Fax

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

Please indicate if any of the following apply:		
<input type="checkbox"/> MVA	<input type="checkbox"/> Liability	<input type="checkbox"/> Worker's Compensation

- Notes are required including most recent testing to make a determination.
- PT prior authorization is required after the 6th visit. OT and ST require prior authorization after the initial evaluation.

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