group health Cooperative of eau claire

Prior Authorization Form
PT/OT

Please indicate the type of therapy you are requesting (For speech therapy, please use specific form):

☐ Physical ☐ Occupational

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

Ordering Physician:_____ Clinic: _____

Therapy Provider: _____ Tax ID: _____ NPI: _____
Name/Specialty/Clinic

Phone:_____ Fax: _____

Diagnosis:_____ ICD-10:_____ Date of Initial Eval: _____

Is this a Worker's Comp or accident case? ☐ Yes ☐ No

Dates of service requested: _____

Number of visits requested: _____

PLEASE SEND EVALUATION AND MOST RECENT PROGRESS NOTE FOR FIRST REQUEST ONLY. ADDITIONAL REQUESTS WILL NEED ONLY THE MOST RECENT VISIT NOTE. THERAPY REQUESTS MUST INCLUDE THE ENTIRE SCORING SCALE INCLUDING THE STANDARD SCORES AND THE MEMBER'S SCORE.

_____	_____	_____	_____
Provider Contact Name	Phone #	Fax #	Date

Prior authorization is not required for the initial evaluation and next five visits (first six visits) per calendar year. If additional visits are needed, authorization is required prior to the seventh visit. Services must be prescribed by a Physician to be considered a covered benefit.

Privacy and Confidentiality:
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