Prior Authorization Request

Payment is authorized only for the services noted below and is subject to the limitations and exclusions as outlined in the Member Handbook/Evidence of Coverage. If you have any questions, please contact Member Service at 1-800-460-4641 and TTY users can call 711.

Date of Request:			
Member Information			
Member Name:	ID#:	DOB:	Date:

Provider Information		
Requesting Provider:	Tax ID:	NPI:
Requesting Facility:	Tax ID:	NPI:
Contact Person:	Phone #:	Fax #:

Requested Service Information (include a copy of clinical documentation for requests)	
Requested Service:	Date of service:
Procedure Codes:	
Diagnosis:	ICD-10 Codes:

Place of Service:

☐ Hospital inpatient ☐ Hospital outpatient ☐ Provider's office ☐ Ambulatory surgery center
☐ Home ☐ Other

Frequency of service (if applicable):

_____day(s) per week for _____weeks **or** _____dosage every_____weeks

Please indicate if the requested service is suspected to be a cause of any of the following.

☐ MVA ☐ Liability ☐ Workers Compensation

PLEASE FAX COMPLETED FORM TO:
Health Management Department
Fax: 715-552-7202 or 715-852-5755

OR MAIL TO: Group Health Cooperative of Eau Claire
Health Management Department
PO Box 3217
Eau Claire, WI 54702-3217

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 1-800-460-4641 and destroy this document received. State and Federal Law prohibits any unauthorized use of this information. Thank you for your cooperation.