group health Cooperative of eau claire

Request Form

Admission Event Authorization

Patients Name: _____ DOB: _____ ID# _____

Admitting Physician: _____
Name/Clinic

Facility: _____ Tax ID: _____ NPI: _____
Name of Facility

Procedure: _____ CPT Code: _____

Admitting Diagnosis: _____ ICD-10: _____

Admission Date: _____

Was this an emergency admission? ☐ Yes ☐ No

Bed Type (Check One):

☐ Medical ☐ ICU/CCU ☐ OB ☐ Rehab ☐ Swing
☐ Surgical ☐ NICU ☐ Peds ☐ Observation

Mother/Maternal Child Information

Mother	*Please Indicate:*	Maternal Child	Please Indicate:
Admission Date:		Date of Birth and time:	
Anticipated Discharge Date:		Anticipated Date of Discharge:	
Method of Delivery:		Birth Weight:	
Admitting Provider:		Apgar at 1 minute:	
Delivery Provider:		Apgar at 5 minutes:	
		Gestational Age:	
		Feeding Type:	
		Birth Status:	
		Gender (check one):	☐ Male ☐ Female
		Full Name, if available:	
		Pediatric Provider:	
		Birth Order:	

Please indicate if any of the following is suspected to be a cause of the indicated need for the admission:
☐ MVA ☐ Liability ☐ Workers' Compensation

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

Group Health Cooperative Health Management Response:

Based on information provided this admission will be approved for _____ days.

Target Date of Discharge: _____ Signature, Date: _____

Please note: The facility must notify Health Management upon discharge of patient or by the Target date indicated above. If the patients stay is over the target discharge date the facility representative must call Health Management with clinical information regarding the admission. If assistance with discharge planning services is needed please feel free to call Health Management at (715) 552-7200 or (888) 203-7770.

Privacy and Confidentiality:
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