group health Cooperative of eau claire

Out-of-Network
Prior Authorization Request

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

Provider Information			
Referring Provider	NPI		Fax
Refer to Provider and Specialty	Tax ID		NPI
Diagnosis			ICD-10
Provider Contact Name	Phone	Fax	Request Date

Please indicate the reason for requesting this out of network service:

Please Select One:

- ☐ Specialty not available within the Cooperative's network of contracted providers
- ☐ Patient has been under the care of this physician for _____ years for this diagnosis
- ☐ Other – Please specify:_____

Projected Appointment Date: _____

Please select one:

- ☐ Consultation and Treatment of the specific condition listed above and limited to _____ visits. (Indicate number of visits.)
- ☐ Surgical follow up as needed and limited to _____ visits. (Indicate number of visits.)
- ☐ Renewal for extended Medical Management of the indicated diagnosis as above and limited to _____ visits. (Indicate number of visits.)

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

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:** 715.552.7202 or 715.852.5755