



Home Health Prior Authorization Request

Member Information

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

Provider Information

Prescribing Provider	Tax ID	Fax
Home Health Provider	Tax ID	NPI
Diagnosis	ICD-10	
Provider Contact Name	Phone	Fax
Start Date	Request Date	

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

Please indicate services requested and frequency:

<input type="checkbox"/> Home Health Aid	Frequency _____
<input type="checkbox"/> Personal Care Worker	Frequency _____
<input type="checkbox"/> Skilled Nursing	Frequency _____
<input type="checkbox"/> Physical Therapy	Frequency _____
<input type="checkbox"/> Occupational Therapy	Frequency _____
<input type="checkbox"/> Speech Therapy	Frequency _____

Please indicate if any of the following apply:

MVA Liability Worker's Compensation Indicate if this is an urgent request

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:** 715.852.5755