



Home Health Prior Authorization Request

Member Information

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

Requesting Practitioner	Practitioner Tax ID	Practitioner NPI
Home Health Facility	Facility Tax ID	Facility NPI
Facility Address		
Diagnosis		ICD-10
UM Contact Name	UM Phone	UM Fax
Start Date		

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

Please indicate services requested and frequency:

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

Please indicate if any of the following apply:

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

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Please fax completed form to: Group Health Cooperative of Eau Claire **Fax:** 715.552.7202