group health Cooperative of eau claire

# 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:**

- ☐ Home Health Aid — Frequency _____
- ☐ Personal Care Worker — Frequency _____
- ☐ Skilled Nursing — Frequency _____
- ☐ Physical Therapy — Frequency _____
- ☐ Occupational Therapy — Frequency _____
- ☐ Speech Therapy — Frequency _____

**Please indicate if any of the following apply:**

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



**Please fax completed form to:** Group Health Cooperative of Eau Claire **Fax:** 715.852.5755