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