group health Cooperative of eau claire

Prior Authorization Form

Cardiac & Pulmonary Rehab

Please indicate the type of rehabilitation you are requesting:

☐ Cardiac ☐ Pulmonary

Patient's Name:_____ DOB:_____ ID#_____

Ordering Physician:_____ Clinic: _____

Rehabilitation Provider: _____ Tax ID: _____ NPI: _____
Name/Specialty/Clinic

Phone:_____ Fax: _____

Diagnosis:_____ ICD-10:_____

Is this a Worker's Comp or accident case? ☐ Yes ☐ No

Dates of service requested: _____

Number of visits requested: _____

Provider Contact Name	Phone #	Fax #	Date

Prior authorization is required prior to any services being rendered. Services must be prescribed by a Physician to be considered a covered benefit.