group health Cooperative of eau claire

Request Form

Home Health Authorization

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

Ordering Physician:_____ Tax ID: _____ Fax#: _____
Name/Clinic

Home Health Provider: _____ Tax ID: _____ NPI: _____

Phone: _____ Fax: _____

Diagnosis:_____ ICD-10:_____

Please provide clinical information for justification of need for service along with 485 or 486

Admission Date: _____

Skilled Nursing Frequency: _____

Please indicate additional services and frequency being provided:

☐ Home Health Aid Frequency _____

☐ Personal Care Worker Frequency _____

☐ Physical Therapy Frequency _____

☐ Occupational Therapy Frequency _____

☐ Speech Therapy Frequency _____

Projected End Date of Service: _____

Please indicate if any of the following is suspected to be a cause of the indicated need for the medication:

☐ MVA ☐ Liability ☐ Workers' Compensation ☐ Indicate if this is an emergent request

Please note: In the case of an emergent medical need for a service event authorized service, a service event request with clinical justification of the emergent need must be faxed to the Health Management Department as soon as possible before the services are performed. Please indicate on your request the need for an emergent review.

_____	_____	_____	_____
Provider Contact Name	Phone #	Fax #	Date

Please refer to the Provider Manual for specific information regarding the need for service event authorizations.

Privacy and Confidentiality:
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