group health Cooperative of eau claire

# Day Treatment/Partial Hospitalization
## Prior Authorization Request

| Member Information | | |
|---|---|---|
| Member Name | Date of Birth | Member ID |
| | | |

| Diagnosis | ICD-10 | Date of Admission _____<br>Hours per week _____<br>☐ Mental Health ☐ AODA |
|---|---|---|
| | | |

**Past Levels of Care Attempted**

Outpatient? If yes, when and where

Inpatient? If yes, when and where

| Provider Information | | |
|---|---|---|
| Practitioner Name | Practitioner Tax ID | Practitioner NPI |
| | | |
| Facility Name | | |
| | | |
| Facility Address | Facility Tax ID | Facility NPI |
| | | |
| UM Contact Name | UM Phone | UM Fax |
| | | |

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

Health Check screening documentation is required with this request. Members without a Health Check screening performed within the past 12 months will not be approved for this service. General follow up or problem focused appointments with a primary care provider do not qualify as a Health Check.



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