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 _____ Estimated Length of Stay _____ ☐ Mental Health ☐ AODA

Past Levels of Care Attempted

Outpatient? If yes, when and where

Inpatient? If yes, when and where

Provider Information		
Provider Name	Facility Name	
Address	NPI	Tax ID
Contact Name	Phone	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** 715.852.5755