



Day Treatment/Partial Hospitalization Prior Authorization Request

Member Information		
Member Name	Date of Birth	Member ID
Diagnosis	ICD-10	Date of Admission _____ Hours per week _____ <input type="checkbox"/> Mental Health <input type="checkbox"/> 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.

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