



Inpatient Admission Prior Authorization and Notification

Member Information		
Member Name (please print)	Date of Birth	Member ID

Provider Information		
Admitting Physician		NPI
Name of Facility	Tax ID	NPI
Procedure		CPT Code
Admitting Diagnosis		ICD-10
Admission Date	Admission Status <input type="checkbox"/> Inpatient <input type="checkbox"/> Observation	Request Date
Facility Contact Name	Phone	Fax

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

Newborn Information (If applicable)		
Date of Birth	Birth Weight	Gender (check one) <input type="checkbox"/> Male <input type="checkbox"/> Female
Full Name (if available)		

Please indicate if any of the following apply:
<input type="checkbox"/> MVA <input type="checkbox"/> Liability <input type="checkbox"/> Worker's Compensation

Privacy and Confidentiality: The information within this fax message is intended for the recipient(s) only. If you have received this fax in error, please contact us at (715) 552-4300 and destroy this document received. State and Federal Law prohibits any unauthorized use of this information. Thank you for your cooperation.

Please fax completed form to: Group Health Cooperative of Eau Claire **Fax:** 715.852.5755