

**HEALTHCARE COOPERATIVE** 

Common Ground Healthcare Cooperative PO Box 1630 Brookfield, WI 53008-1630

T: 877.825.9293 | F: 715.221.9749

## **General Medical Prior Authorization Form Prior Authorization Request**

rior Authorizatio	t	Date				
Member Information						
ember name			Member ID		Date of Birth (mm/dd/yy)	
ist of patient's diagnosis/condition	1					
Referring Provider Inform	nation					
Referring provider's name			Specialty		Telephone Number	
eferring provider's address						
Contact person, if more information is needed Title		Title	Telephone Number		Fax Number	
Rendering Provider Infor	mation					
lendering provider's name			Specialty		NPI	
Where will the services be rendere	d? (name of practice	e/facility and location)				
Contact person, if more informatio	n is needed	Title		Telephone Number	Fax Number	
<ul> <li>Is an appointment sche</li> <li>What are the specific set</li> <li>□ Office Visit/secon</li> <li>Note: CGHC network provider within the network, a clear exadequately addresses the pat medically necessary by CGHC.</li> <li>List of applicable CPT/IC</li> </ul>	ervices being red d opinion as should be used for splanation of why the ient's condition is av	Ancillary Se second and third opine in-network service co	ions in all b annot be us	out unusual circumstances. If ed must be provided in #9 be	low. If a procedure that	
Has this patient received treatment for this condition from affiliated providers within Ves No CGHC's network?						
If yes, indicate the prov	iders who have	seen this patient				
. Explain why an affiliated	d provider canno	ot provide the req	uested se	ervices		
Provide any supportive d					Date	
Mail or fax form to:		Common Ground Healthcare Cooperative PO Box 1630				
	Brookfield	d, WI 53008-1603				
	Fax 715.2	21.9749				