Common Ground Healthcare Cooperative
PO Box 1630
Brookfield, WI 53008-1630
T: 877.825.9293 | F: 715.221.9749

General Prior Authorization Form

Prior Authorization Request

Date _____

Member Information		
Member name	Member ID	Date of Birth (mm/dd/yy)
List of patient's diagnosis/condition		

Referring Provider Information			
Referring provider's name	Specialty	Telephone Number	
Referring provider's address			
Contact person, if more information is needed	Title	Telephone Number	Fax Number

Rendering Provider Information			
Rendering provider's name	Specialty	NPI	
Where will the services be rendered? (name of practice/facility and location)			
Contact person, if more information is needed	Title	Telephone Number	Fax Number

1. Has patient seen this provider in the past? Yes ☐ No ☐ If yes, when? _____
2. Is an appointment scheduled? Yes ☐ No ☐ If yes, when? _____
3. What are the specific services being requested?

   ☐ Office Visit/second opinion ☐ Ancillary Service ☐ Procedure ☐ Other _____

   Note: *CGHC network providers should be used for second and third opinions in all but unusual circumstances. If the services are available within the network, a clear explanation of why the in-network service cannot be used must be provided in #9 below. If a procedure that adequately addresses the patient's condition is available within the network, a referral outside the network is likely to be determined as not medically necessary by CGHC.*
4. List of applicable CPT/ICD Codes

   _____
5. Has this patient received treatment for this condition from affiliated providers within CGHC's network? Yes ☐ No ☐

   If yes, indicate the providers who have seen this patient _____
6. Explain why an affiliated provider cannot provide the requested services _____

   _____

Provide any supportive documentation as appropriate for this referral.

_____ _____

Provider signature Date

Mail or fax form to: Common Ground Healthcare Cooperative
PO Box 1630
Brookfield, WI 53008-1603
Fax 715.221.9749