CONTRA COSTA HEALTH PLAN
A Division of Contra Costa Health Services

PROCEDURE/SERVICES
PRIOR AUTHORIZATION REQUEST

Fax Authorization Requests to CCHP
Phone: 925-957-7260 Fax: 925-313-6058

Illegible or Incomplete forms will be returned

Name:

Member ID #

Phone:

DOB:

☐ **If urgent, check box. INAPPROPRIATE USE WILL BE MONITORED**

DATE REQUESTED: _____

Is condition: ☐ work related? ☐ related to an auto accident? ☐ covered by CCS? If yes, obtain authorization from CCS.

Secondary Carrier:_____

Requested Specialty/Service:_____Phone#: _____

Provider/Vendor (**NOT REQUIRED**):_____Fax#:_____

DX_____CPT_____ICD-9_____

☐ Initial Consult/Evaluation ☐ Inpatient_____days ☐ Procedure/Test_____

☐ Follow-up_____visits ☐ Other_____

REQUESTING PROVIDER: _____

SIGNATURE: _____

How do we reach you if more info is needed? Phone#:_____Fax#: _____

If different from the above, give name of person completing this form:_____

JUSTIFICATION (Complete or send pertinent information, i.e. consult/progress notes, test results, signs and symptoms)

IMPORTANT NOTICE: Incomplete forms will be sent back for completion. Unauthorized, non-emergent, or non-urgent services rendered without prior authorization and/or after valid authorized dates are subject to payment denial. Please allow CCHP the following turnaround time to make a decision **after receipt of reasonably necessary information**: Standard: up to 5 business days, Urgent: up to 72 hours.

DO NOT USE THIS FORM FOR:

- **Bone Growth Stimulator**
- **TENS Unit**
- **Manual Wheelchair**
- **Motorized Wheelchair/Power Operated Vehicle**
- **Anti-Obesity Medication**
- **Gastric Surgery**
- **Incontinence Supplies (Medi-Cal Only)**

CALL THE AUTHORIZATION UNIT FOR APPLICABLE WORKSHEET

PRIOR AUTHORIZATION IS REQUIRED FOR(but not limited to):

- Chemo/Radiation Therapy (not related to cancer), Cancer Clinical Trials
- Child Development Center, Craniofacial Clinic, Healthy Hearts (Children's Hospital Oakland)
- Dialysis
- Follow up visits
- Home Health Services including Hospice & Home Infusion Therapy
- Inpatient admissions including OB, Acute Rehab, SNF & Hospice
- Neurosurgery Consult & Procedures
- Non-contracted providers & Tertiary Care
- Non-emergency Transportation
- DME, including Oxygen, Non-reusable Medical Supplies & Hearing Aids
- EMG, NCS & ENG
- Genetic or DNA testing
- Organ Transplant Evaluations
- Out-of-area services
- Outpatient Surgery and Facility based procedure
- PET Scans & Total Body Scans
- Prosthetics, Appliances, Braces & Orthotics
- Psychiatry (M.D.) visits
- Referral of PCP to self for special services (e.g. surgery)
- RAST or MAST testing
- Rehabilitation services including Physical, Occupational, Speech Therapy & Cardiac or Pulmonary Rehab
- Services not available at CCRMC/HC
- Specialist referrals for RMCN: Initial & follow up visits
- Sub-specialty i.e. Pain Management, Urogyn, Weight Loss Clinic, Sleep Lab, etc.

AUTHORIZATION IS CONTINGENT UPON VERIFICATION OF ELIGIBILITY AT THE TIME OF ADMISSION OR AT THE TIME SERVICES ARE RENDERED

PLEASE DO NOT WRITE IN THE SECTION BELOW FOR CCHP/PCN USE ONLY

☐ Approved Authorization Number: _____ Effective Date: _____
☐ Modified Approved per criteria#: _____ Expiration Date: _____
☐ Denied Reason for Denial _____
☐ Pt. not eligible HPAR/RN/MD Signature _____ Date _____

MEDI-CAL MEMBERS: May self-refer to Dental care by calling: 800-322-6384 and self-refer for Mental Health services by calling 1-888-678-7277