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.

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

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 & Cardiac MRI
- 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.

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 (888) 678-7277