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**

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: ____________________________

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

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 ____________________________

MEDICAL 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