CONTRA COSTA HEALTH PLAN
UTILIZATION MANAGEMENT UNIT

DISCLOSURE OF CRITERIA OR GUIDELINES
REQUEST FORM

Phone (925) 957-7260 Option 3, Fax (925) 313-6458, ATTN: INTERNAL AUDIT/CHARGE RN

Date: _________________________

Requestor: _________________________

Agency/Company: _________________________

Address: _________________________

Phone: _________________________ Fax: _________________________

Specific Criteria or Guideline Requested: _________________________

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The materials provided to you are guidelines used by this plan to authorize, modify, or deny care for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under your contract.

For Contra Costa Health Plan only:

Date request: _________________________

Date Criteria/Guideline: _________________________ Initials: _________________________

Publisher and Title of Criteria/Guideline sent: _________________________

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Appendix M - Disclosure of UM Criteria or Guidelines Request Form.doc