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.
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.**

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**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 (888) 678-7277

PA001 (02/2019)