CONTRA COSTA HEALTH PLAN
UTILIZATION MANAGEMENT UNIT

DISCLOSURE OF CRITERIA OR GUIDELINES
PROVIDER REQUEST FORM

Date:

Requestor:

Agency/Company:

Address:

Phone: _____ Fax: _____

Specific Criteria or Guideline Requested:

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.

Email: CCHPAuthorizations@cchealth.org **Phone:** (925) 957-7260 Option 3

Fax: (925) 313-6458, ATTN: CHARGE RN

Mailing Address: 595 Center Ave. Ste 100., Martinez CA 94553

For Contra Costa Health Plan only:

Date request _____

Date Criteria/Guideline _____

Publisher and Title of Criteria/Guideline sent: Initials: _____