

Authorization Review Form for Health Care Services

Marketplace

MEDICAL SERVICES

Pre-Authorizations Fax: 713.295.7019
Admission Notifications Fax: 713.295.2284
IP Concurrent Review Fax:
713.295.7030 or 1.844.899.2496

BEHAVIORAL HEALTH SERVICES

Pre-Authorization OP Fax: 713.576.0930
Pre-Authorization IP Fax: 713.576.0932

URGENT REQUESTS: 713.295.6704

Medicaid/CHIP

MEDICAL SERVICES

Pre-Authorizations Fax:
713.295.2283 or 1.844.899.2495
Admission Notifications Fax:
713.295.2284 or 1.844.831.8323
IP Concurrent Review Fax:
713.295.7030 or 1.844.899.2496

BEHAVIORAL HEALTH SERVICES

Pre-Authorizations OP Fax: 713.576.0931
Pre-Authorizations IP Fax: 713.576.0932

URGENT REQUESTS: 713.295.2295

HMO D-SNP

MEDICAL SERVICES

Pre-Authorizations Fax: 713.295.7059

BEHAVIORAL HEALTH SERVICES

Pre-Authorization OP/IP Fax: 713.576.0939

URGENT REQUESTS: 713.295.5007

Providers must submit the Prior Authorization Request Form. The form must include the following information:

- Member Name
- Member Date of Birth
- Member Medicaid/CHIP Identification Number
- Requesting Provider Name and National Provider Identifier (NPI)
- Servicing Provider Name and NPI
- Quantity of service units requested based on the CPT, HCPCS, or CDT requested
- Requesting Provider's signature and date
- Requested Service
 - Current Procedural Terminology (CPT) Codes
 - Healthcare Common Procedure Coding System (HCPCS), or
 - Current Dental Terminology (CDT)
 - Service requested start and end date(s)

Please note any prior authorization requests missing information will not be processed and a new request will need to be submitted.

For additional information, please visit our website at <https://provider.communityhealthchoice.org/resources/prior-authorization-information/>

Failure to Complete All Applicable Fields May Delay Processing

SECTION I — SUBMISSION

Issuer Name:	Phone:	Fax:	Request Date:
--------------	--------	------	---------------

SECTION II — GENERAL INFORMATION

Review Type: <input type="checkbox"/> Non-Urgent <input type="checkbox"/> Urgent	Clinical Reason for Urgency:
Request Type: <input type="checkbox"/> Initial Request <input type="checkbox"/> Extension <input type="checkbox"/> Amendment	Prev. Auth. #:
<input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> Provider Office <input type="checkbox"/> Observation <input type="checkbox"/> Home <input type="checkbox"/> Day Surgery Other: _____	

SECTION III - PATIENT INFORMATION

Name:	Phone:	DOB:	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other <input type="checkbox"/> Unknown
Subscriber Name (if different):	Member or Medicaid ID #:	Plan Name:	

SECTION IV - PROVIDER INFORMATION

Requesting Provider or Facility		Service Provider or Facility	
Name:	Tax ID:	Name:	Tax ID:
NPI #:	Specialty:	NPI #:	Specialty:
Phone:	Fax:	Phone:	Fax:
Contact Name:	Phone:	Primary Care Provider Name (see instructions):	
Requesting Provider's Signature and Date:		Phone:	Fax:

SECTION V - SERVICES REQUESTED (with CPT, CDT, REV or HCPCS code) and supporting diagnoses (with ICD CODE)

<input type="checkbox"/> Physical Therapy <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Speech Therapy <input type="checkbox"/> Cardiac Rehab <input type="checkbox"/> Mental Health/Substance Abuse	
<input type="checkbox"/> Home Health (MD Signed Order Attached?) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DME (MD Signed Order Attached?) <input type="checkbox"/> Yes <input type="checkbox"/> No Equipment/Supplies (include any HCPCS Codes): <input type="checkbox"/> Yes <input type="checkbox"/> No	Nursing Assessment Attached? <input type="checkbox"/> Yes <input type="checkbox"/> No Title 19 Certification Attached? (Medicaid Only) <input type="checkbox"/> Yes <input type="checkbox"/> No Duration: _____
<input type="checkbox"/> Other Services: _____	

Planned Service or Procedure	Code (CPT, HCPCS, Revenue Code)	Units	Start Date	End Date	Diagnosis Description	ICD-10 Code

An issuer needing more information may call the requesting provider directly at: _____

**** Required: Attach clinical documentation to this form upon submission.****