PHYSICAL HEALTH PRIOR AUTHORIZATION REQUEST

After completing this form, fax it to: 1-877-232-5976

Today's Date _____

☐ New Request ☐ Revised Request of Authorization #_____

☐ CHP+ HMO ☐ CHP+ SMCN

It is best to plan ahead and submit an authorization request well in advance of the service being rendered. Authorization requests are processed as quickly as the member's health condition requires, and within the specific line of business requirements. Determination of this request will be provided via fax to the "Contact for Determination" listed below.

Member Name:	DOB:	Member ID:
Does this member have other insurance? ☐ No ☐ Yes	If yes, specify:	
Requesting provider:		TIN:
Provider Phone:	Provider Fax:	
Facility/office where service is to take place:		TIN:
Contact for Determination Notification:		
Phone:	Fax:	

SERVICES:

☐ Inpatient Admit/Procedure ☐ Outpatient Procedure/Surgery ☐ Office

☐ Enteral Nutrition/Formula and Supplies ☐ Specialist Referral

☐ Transplant (if transplant, which organ?):

Date of service: Description of services:

CPT code(s):

CPT description:

HCPCS code(s):

HCPCS description:

ICD-10 Dx code(s):

Diagnosis description:

If patient is pregnant, provide EDC:

DON'T FORGET TO ATTACH CLINICAL NOTES WITH THIS REQUEST TO AVOID PROCESSING DELAYS.

We are not financially responsible for the services that are preauthorized if the patient is not eligible on the date services are provided. This request is not a guarantee of payment. Eligibility must be verified at time service is rendered. For questions regarding eligibility of a member, please call us at the numbers below.

Refer to the provider manual and authorization list on our website at www.coaccess.com/for-providers for additional details and information about the prior authorization process.

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