

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/](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="radio"/> Yes <input type="radio"/> No Nursing Assessment Attached? <input type="radio"/> Yes <input type="radio"/> No <input type="checkbox"/> DME (MD Signed Order Attached?) <input type="radio"/> Yes <input type="radio"/> No Title 19 Certification Attached? (Medicaid Only) <input type="radio"/> Yes <input type="radio"/> No Equipment/Supplies (include any HCPCS Codes): <input type="radio"/> Yes <input type="radio"/> 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 |
|------------------------------|---------------------------------|-------|------------|----------|-----------------------|-------------|
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An issuer needing more information may call the requesting provider directly at: _____

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