COMMUNITY HEALTH CHOICE

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/

COMMUNITY HEALTH CHOICE

Failure to Complete All Applicable Fields May Delay Processing

SECTION I —SUBMISSION

Issuer Name:	Phone:	Fax:	Request Date:

SECTION II — GENERAL INFORMATION

Review Type: ☐ Non-Urgent ☐ Urgent	Clinical Reason for Urgency:
Request Type: ☐ Initial Request ☐ Extension ☐ Amendment	Prev. Auth. #:
☐ Inpatient ☐ Outpatient ☐ Provider Office ☐ Observation ☐ Home ☐ Day Surgery Other:_____	

SECTION III - PATIENT INFORMATION

Name:	Phone:	DOB:	☐ Male ☐ Female ☐ Other ☐ Unknown
Subscriber Name (if different):	Member or Medicaid ID #:		Plan Name:

SECTION IV - PROVIDER INFORMATION

Requesting Provider or Facility	
Name:	Tax ID:
NPI #:	Specialty:
Phone:	Fax:
Contact Name:	Phone:
Requesting Provider's Signature and Date:	

Service Provider or Facility	
Name:	Tax ID:
NPI #:	Specialty:
Phone:	Fax:
Primary Care Provider Name (see instructions):	
Phone:	Fax:

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

☐ Physical Therapy ☐ Occupational Therapy ☐ Speech Therapy ☐ Cardiac Rehab ☐ Mental Health/Substance Abuse

☐ Home Health (MD Signed Order Attached?) ◯ Yes ◯ No Nursing Assessment Attached? ◯ Yes ◯ No

☐ DME (MD Signed Order Attached?) ◯ Yes ◯ No Title 19 Certification Attached? (Medicaid Only) ◯ Yes ◯ No

Equipment/Supplies (include any HCPCS Codes): ◯ Yes ◯ No Duration: _____

☐ 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.**