

# Prior Authorization Request Form



Committed to your health.

<b>Fax PA Request + chart notes to:</b> Community Health Plan, Attn: UM Department Fax#: 206.613.8873	<b>Emergent PA request:</b> Fax PA form + clinical Information and CALL customer Service (800.440.1561) to let us know it's coming
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**Verify Eligibility and Benefits.** Check to be sure that the service/DME being requested requires Prior Authorization before sending your request. Call CHP Customer Service at 1-800-440-1561 (for Medicare Advantage please call 1.800.942.0247)  
 INCOMPLETE FORMS MAY BE RETURNED. REQUESTS WITHOUT CLINICAL INFORMATION WILL DELAY PROCESSING.

**A complete list of services requiring prior authorization may be found at: [www.chpw.org](http://www.chpw.org)**

ORDERING PROVIDER INFORMATION (MD, DO, ARNP/FNP OR PA-C ONLY)			
Ordering Provider (Print first and last name)	Person completing form	Phone #	Fax #
<input type="checkbox"/> Ordering provider is PCP. PCP's Clinic name _____ MSO # _____			
<input type="checkbox"/> Ordering provider is Specialist: Specialty: _____			
If non-participating, do you have a referral on file: <input type="checkbox"/> Yes <input type="checkbox"/> No (If no, this request will be returned)			
PATIENT INFORMATION			
Name (print first and last name)	Date of Birth	CHP Member ID	Plan/Program <input type="checkbox"/> Healthy Options <input type="checkbox"/> CHIP <input type="checkbox"/> GAU
			<input type="checkbox"/> Basic Health Plus(BH+) <input type="checkbox"/> Basic Health (BH) <input type="checkbox"/> Medicare Advantage
SERVICE REQUEST:			
Please Check <b>Clinical</b> Urgency of request: <input type="checkbox"/> Routine <input type="checkbox"/> Urgent			
Who will be the TREATING Provider	Specialty	Contact Telephone #	Contact Fax #
<input type="checkbox"/> Participating <input type="checkbox"/> Non-Participating			
Who will be the FACILITY provider:	<input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient	Contact Telephone #	Contact Fax #
<input type="checkbox"/> Participating <input type="checkbox"/> Non-Participating			
<b>Diagnoses</b> Primary: Code ( _____ ) Name: _____ Secondary: Code ( _____ ) Name: _____		<input type="checkbox"/> New Request <input type="checkbox"/> Extension Request* # Visits _____ Duration: _____ *Last date of service if an extension: _____	
Describe services being requested:			Planned Date of Service:
CPT /HCPCS #1 _____ Description: _____			<b>Please attach supporting clinical documentation to this fax.</b>
CPT /HCPCS #2 _____ Description: _____			
CPT /HCPCS #3 _____ Description: _____			
CPT /HCPCS #4 _____ Description: _____			

**TO CHECK ON THE STATUS OF YOUR REQUEST, PLEASE CALL CHP CUSTOMER SERVICE (800)440-1561 (For Medicare Advantage call 1.800.942.0247 )**

Payment is subject to member eligibility and benefits at the time of service; a prior-authorization is not a guarantee of payment.