

Prior Authorization Request Form



COMMUNITY HEALTH PLAN
of Washington™

Community HealthFirst™
Medicare Advantage Plans

For expedited processing for both Apple Health/Medicaid and Medicare Advantage Plans please submit Prior Authorization requests via the Care Management Portal at www.chpw.org/submitcare.

Alternately, you can fax Prior Authorization requests to the appropriate number below:

For Apple Health/Medicaid:

Prior Authorizations requests may be faxed to:
206-613-8873

Please call Customer Service to verify eligibility & benefits:
1-800-440-1561;
Monday through Friday,
8 a.m.-5 p.m.

For Medicare Advantage Plans:

Prior Authorizations requests may be faxed to:
206-652-7065

Please call Customer Service to verify eligibility & benefits:
1-800-942-0247;
7 days a week, 8 a.m.-8 p.m.

- A complete list of services requiring Prior Authorization may be found at www.chpw.org
- **With your submitted form, please attach supporting clinical documentation.**
- Incomplete forms and requests without clinical information will delay processing
- A Prior Authorization is not a guarantee of payment; Payment is subject to member eligibility and benefits at the time of service

ORDERING PROVIDER INFORMATION					
First Name:		Last Name:		Contact Phone #:	Contact Fax #:
Contact Person at this office:			<input type="checkbox"/> Ordering provider is PCP PCP's Clinic Name:	<input type="checkbox"/> Ordering provider is Specialist Specialty:	
PATIENT INFORMATION					
First Name:		Last Name:		MI:	Date of Birth:
CHPW Member ID:		<input type="checkbox"/> Patient Retro Enrolled with CHPW		Retro Enrolled Date:	
SERVICE PROVIDED BY					
First Name:		Last Name:		Address:	
<input type="checkbox"/> Participating <input type="checkbox"/> Non-Participating	Tax ID: NPI:	Specialty:	Contact Phone #:	Contact Fax #:	
Facility Name:			Address:		
<input type="checkbox"/> Participating <input type="checkbox"/> Non-Participating	Tax ID: NPI:	Specialty:	Contact Phone #:	Contact Fax #:	
<input type="checkbox"/> Inpatient	<input type="checkbox"/> Outpatient	Please indicate CLINICAL urgency of request: <input type="checkbox"/> Routine <input type="checkbox"/> Urgent			
Diagnosis: Primary: Code (_____) Description: _____ Secondary: Code (_____) Description: _____				Date of Service:	
Services being requested:				<input type="checkbox"/> New request <input type="checkbox"/> Extension	
CPT /HCPCS #1 _____	Description: _____		Request*		
CPT /HCPCS #2 _____	Description: _____		# Visits: _____ Duration: _____		
CPT /HCPCS #3 _____	Description: _____		*Last Date of service if an extension _____		