Prior Authorization Request Form

COMMUNITY HEALTH PLAN of Washington™ | COMMUNITY HEALTH NETWORK of Washington™

APPLE HEALTH (MEDICAID) MEDICARE ADVANTAGE CASCADE SELECT

For expedited processing for both Apple Health/Medicaid, Medicare Advantage Plans and CHNW-Cascade Select please submit Prior Authorization requests via the Care Management Portal at **chpw.org/submitcare** or **cascadeselect.org**.

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

For Apple Health/Medicaid:	For Medicare Advantage Plans:	For Cascade Select:
Fax: (206) 652-7078	**Fax: (206) 652-7065**	**Fax: (206) 652-7050**
Notification is required by next business day	Notification is required within 24 hours	Notification is required within 24 hours
Please call Customer Service to verify eligibility & benefits: **1-800-440-1561; Monday through Friday, 8 a.m.-5 p.m.**	Please call Customer Service to verify eligibility & benefits: **1-800-942-0247; 7 days a week, 8 a.m. - 8 p.m.**	Please call Customer Service to verify eligibility & benefits: **1-866-907-1906; Monday through Friday, 8 a.m.-5 p.m.**

- Please refer to the Procedure Code Lookup Tool on the website **https://forms.chpw.org/pclt** for all the services that require prior authorization.
- **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: ☐ Ordering provider is PCP — PCP's Clinic Name: ☐ Ordering provider is Specialist — Specialty:

PATIENT INFORMATION

First Name:	Last Name:	MI:	Date of Birth:

Member ID: ☐ Patient Retro Enrolled with CHPW Retro Enrolled Date:

SERVICE PROVIDED BY

First Name:	Last Name:	Address:

☐ Participating ☐ Non-Participating	Tax ID: NPI:	Specialty:	Contact Phone #:	Contact Fax #:

Facility Name: Address:

☐ Participating ☐ Non-Participating	Tax ID: NPI:	Specialty	Contact Phone #:	Contact Fax #:

☐ Inpatient ☐ Outpatient Please indicate **CLINICAL** urgency of request ☐ Routine ☐ Urgent

Diagnosis: Primary: Code (_____) Description:_____ Date of Service:

Secondary: Code (_____) Description:_____

Services being requested:

CPT /HCPCS #1_____ Description:_____

CPT /HCPCS #2_____ Description:_____

CPT /HCPCS #3_____ Description:_____

☐ New request ☐ Extension Request*

#Visits:_____ Duration: _____

*Last Date of service if an extension _____