Prior Authorization Request Form

COMMUNITY HEALTH PLAN of Washington™ | MEDICARE ADVANTAGE
The power of community

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:	☐ Ordering provider is PCP PCP's Clinic Name:	☐ Ordering provider is Specialist Speciality:

PATIENT INFORMATION

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

CHPW 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: _____

Secondary: Code (_____) Description: _____

Date of Service:

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 _____