Prior Authorization Request Form

COMMUNITY HEALTH PLAN of Washington™
The power of community

For expedited processing for both Apple Health, Medicare Advantage Plans and Cascade Select please submit Prior Authorization requests via the Care Management Portal at https://jiva.chpw.org/cms/ProviderPortal/Controller/providerLogin

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

For Apple Health:	For Medicare Advantage Plans:	For Cascade Select:
Fax: (206) 652-7078	**Fax: (206) 652-7065**	**Fax: (206) 652-7078**
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 _____