

# Community Health Center Network - Prior Authorization and Referral Request Form

Fax Completed Form to: (510) 297-0222

Submit claims to CHCN at:

101 Callan Ave, Suite 300, San Leandro, CA 94577

➔ **Verify eligibility and benefit coverage at (510) 297-0220 or 0210 before providing service. Member must be eligible on date of service and procedure must be a covered benefit.**

➔ **IMPORTANT NOTICE:** Any services rendered beyond those authorized without prior approval from CHCN, will be subject to denial of payment. CHCN may periodically adjust the compensation payable to correct for errors or omissions, recover any overpayments to Provider, or compensate for any underpayment to Provider hereunder.

Request for Authorization – Approval based on clinical review by CHCN. Response time is up to 5 business days

Retro request for Authorization – Approval based on clinical review by CHCN. Response time is up to 30 business days.

Urgent request - Inappropriate use will be monitored. Response time is up to 2 business days.

Referral – Must Be CHCN Contracted Provider

Interested in becoming a CHCN contracted provider?  
If so, please call Provider Relations at (510) 297-0265.

**NOTE:** Please fill out all 5 fields; illegible or incomplete forms will be returned

## 1. WHO IS THE PATIENT WHO NEEDS THE SERVICE?

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_  
Last First

Address \_\_\_\_\_ Phone \_\_\_\_\_

Patient's Health Plan \_\_\_\_\_ Member # \_\_\_\_\_

## 2. WHO IS THE PROVIDER WHO IS REQUESTING THE SERVICE?

Requesting Provider (PRINT) \_\_\_\_\_ Clinic \_\_\_\_\_ Date \_\_\_\_\_

Office Contact \_\_\_\_\_ Phone \_\_\_\_\_ FAX \_\_\_\_\_

## 3. WHAT DOES THE PATIENT NEED?

Services Requested:

Consultation (1 visit only)

Office Visit/Treatment # of visits \_\_\_\_\_

Home Health Care (Describe) \_\_\_\_\_

Procedure Testing (Name & CPT code) \_\_\_\_\_

DME (Supply Code) \_\_\_\_\_

Inpatient Admission

Outpatient Surgery (Requires CPT code)

4. **WHERE OR TO WHOM IS THIS PATIENT BEING REFERRED?** May be name of physician, surgery center, DME supplier, PT agency, radiology facility, etc.

Refer To (*Enter Provider Name NOT the Group Name*) \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ FAX \_\_\_\_\_

5. **WHY IS THIS PATIENT BEING REFERRED?** Reason for referral should include the diagnosis (ICD code) or a description of the patient's condition; include clinical explanation when necessary; progress notes may need to be attached. What clinical question needs to be answered?

Relevant ICD-9 code(s)

## TO BE COMPLETED BY CHCN STAFF

Authorization # \_\_\_\_\_

Eligible  Yes  No Covered Benefit  Yes  No  Co-pay \_\_\_\_\_

Approved Expiration Date Total # of Visits \_\_\_\_\_

DENIED Comments: \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

➔ **NOTE:** The information being transmitted contains information that is confidential, privileged and exempt from disclosure under applicable law. It is intended solely for the use of the individual or the entity to which it is addressed. If you are not the intended recipient, you are hereby notified that any use, dissemination, or copying of this communication is strictly prohibited. If you have received this communication in error, notify us at once so that we may take the appropriate action. Thank you for your cooperation. Revised: V4.03/04/09