Please Don't Handwrite!
Download this PDF file and type in the data fields before printing. You can save your data in the PDF file.

CHCN Prior Authorization Request

Fax: (510) 297-0222 **Telephone:** (510) 297-0220
Note: All fields that are **BOLDED** are required.

Authorizations are based on medical necessity and covered services. Authorizations are contingent upon member's eligibility and are not a guarantee of payment. The provider is responsible for verifying member's eligibility on the date of service.

Member must be eligible on date of service and procedure must be a covered benefit. REMAINING BALANCE MAY NOT BE BILLED TO THE PATIENT. If interested in becoming a CHCN contracted provider, contact Provider Services at 510-297-0200. Please verify eligibility using one of the following methods:

1. Web: https://connect.chcnetwork.org
2. CHCN Customer Services: (510) 297-0220

TYPE OF REQUEST (please select only one):	**REQUESTING PROVIDER**
Routine Approval based on CHCN clinical review. CHCN has up to 5 business days to process routine requests.	**Name:**
Urgent Inappropriate use will be monitored. CHCN has up to 72 hours to process urgent requests for all lines of business.	Address:
Retro Authorization requests submitted after services are rendered will NOT be reviewed. 30 day limitation, approved on exception basis only. CHCN has up to 30 calendar days to process retro requests from the date of receipt of request.	City: State: Zip:
	NPI #:
Modification Request for existing authorized services. Please enter the CHCN Auth Number and the Member information below. Use a separate sheet to specify your changes or to attach additional supporting documentation.	**Office Contact:**
	Phone: **Fax:**
If Mod, CHCN AUTH #:	**Email:**

MEMBER (For newborn services provide mother's information and check newborn fields below)

First Name:	**Health Plan ID#:**
Last Name:	Newborn? DOB:
Date of Birth:	Phone:
Address:	Other Insurance (i.e. Commercial, Medicare A, B):
City: State: Zip:	

PLACE OF SERVICE:

Inpatient **Outpatient** **Doctor's Office** **Ambulatory Surgical Center** **DME** **HHA**

AUTHORIZE TO

Name/Facility:	Phone:
Specialty/Dept:	Fax:
NPI #:	Address:
Anticipated Date of Service:	City: State: Zip:

Non-Contracted. Please do not enter general comments here. Only give reason for out of network provider request.

DIAGNOSES / SERVICE CODES **ICD-10 codes required beginning 10/01/2015. Only enter the code, modifier, and quantity.**

ICD Code(s):									

CPT/HCPCS	Mod	**Qty**	CPT/HCPCS	Mod	Qty	CPT/HCPCS	Mod	Qty	CPT/HCPCS	Mod	Qty

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 have received this communication in error, please immediately notify us.

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