COMMUNITY HEALTH CENTER NETWORK

Please Don't Handwrite!
Type in the data and fax from your system. You can save the PDF file. All **bolded fields** are required.

Prior Authorization Request

Fax: (510) 297-0222 **Telephone:** (510) 297-0220

Authorizations are contingent upon member's eligibility, medical necessity, and covered services, and are not a guarantee of payment. The provider is responsible for verifying member's eligibility on the date of service. Procedure must be a covered benefit. REMAINING BALANCE MAY NOT BE BILLED TO THE PATIENT.

Please verify eligibility using either: Web: https://connect.chcnetwork.org or CHCN Customer Services: (510) 297-0220.

TYPE OF REQUEST (please select only one):

- ☐ **Routine** Approval based on CHCN clinical review. CHCN has up to 5 business days to process routine requests.
- ☐ **Urgent** Inappropriate use will be monitored. CHCN has up to 72 hours to process urgent requests for all lines of business.
- ☐ **Retro** Please provide the date of service(s) (DOS) rendered. Submission timeframe from DOS: Elevance Health (ABC) 30 calendar days and 90 calendar days for AAH. CHCN has up to 30 calendar days from the date of receipt of the request to process the request.
- ☐ **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.

If Mod, CHCN AUTH #:

REQUESTING PROVIDER

Name:	
Address:	
City: State: Zip:	
NPI #:	TIN #:
Office Contact:	
Phone:	**Fax:**
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: (Must check only one box)

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

AUTHORIZE TO

Name/Facility:	Phone:
Specialty/Dept:	Fax:
NPI #: TIN #:	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 **Only enter the code, modifier, and quantity. Do not enter text.**

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. Revised: V12.1 08/2023