



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

<p>Routine Approval based on CHCN clinical review. CHCN has up to 5 business days to process routine requests.</p> <p>Urgent Inappropriate use will be monitored. CHCN has up to 72 hours to process urgent requests for all lines of business.</p> <p>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.</p> <p>Modification Request for existing authorized services. Please enter the <u>CHCN Auth Number</u> and the <u>Member information</u> below. Use a separate sheet to specify your changes or to attach additional supporting documentation.</p>	Name:		
	Address:		
	City:	State:	Zip:
	NPI #:		
	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	

CHCN Prior Authorization Request form is now a fillable PDF form that you can use to type in your information and then print. All fields that are marked in **“Bold”** are mandatory. Please submit an electronically completed form with all the required information to help us service your request faster. The following table provides information regarding expected information in some of the key fields.

Request Type	Please check only one of the four boxes provided. CHCN follows the turnaround times for authorization processing as establish by regulations and the health plans. NOTE: ‘Modification’ requests are considered as ‘Routine’ requests.
Requesting Provider	Please enter information for your practice. For convenience you can type in your information once and then save the file for future use.
Name	Please enter provider name (First name Last name).
NPI#	Please enter the NPI number of the provider.
Office Contact	Please enter name of the office contact (First Name Last Name). CHCN staff will communicate with this person if needed.
If Mod, CHCN Auth #	If you are requesting modification for an existing authorization please enter the authorization number provided to you so that we can uniquely identify your record. Please specify member information in the form as well. Include your modification request on a separate sheet of paper.
Member	Please enter CHCN member information. NOTE: If the requested service is for a newborn please enter mother’s member information below. Newborn care is covered under mothers’ benefit plan during the birth month and one month after that.
First Name	Please enter CHCN member’s first name.
Last Name	Please enter CHCN member’s last name.
Date of Birth	Please enter member’s date of birth in MM/DD/YYYY format.
Health Plan ID #	Please enter member’s Health Plan ID #.
Newborn	Please check this if the authorization request is for a newborn child.
DOB	Please enter new born child’s date of birth in MM/DD/YYYY format.
Other Insurance	If the member has other insurance coverage please mention insurance id.
Place of Service	For all future elective procedures please check ‘Inpatient’. For other services check appropriately. For home health services please check ‘HHA’.
Authorize To	Please enter information about the provider (or facility) that you are requesting authorization for.
Name / Facility	Please enter name (First Name Last Name) of the provider you are authorizing in the request. If you do not know the name please enter the facility information (e.g. UCSF).
Specialty / Dept	Please enter Specialty of the provider or the department if you have entered a facility name above.
NPI #	Please enter the NPI number of the requested provider if available.
Anticipated Date of Service	Please enter the date of service if known. This will help CHCN to verify if the patient is eligible for that service on this date.
Non-contracted	Please check if the provider is not within CHCN contracted provider network
Reason	If you have selected non-contracted provider please enter the reason for requesting an out of network provider. (The reason could be unavailability of the particular specialty within CHCN network).

Diagnoses / Service Code	Please enter ICD-10 codes for diagnoses and CPT/HCPCS codes for request service / equipment / supplies
Diagnoses	Please enter ICD-10 codes to describe diagnoses. At least one code is required for us to process your request. You can enter up to nine diagnoses codes on the form. If you need to enter more than nine please enter your first nine codes and then attach a separate sheet with the rest of the codes.
CPT / HCPCS code	Please enter CPT (or HCPCS) codes for procedures (or equipment/supplies) that you are requesting authorization for. At least one code is required. You can enter up to twelve codes on this form. If you need to enter more than 12 codes please enter your first twelve codes on this form and then attach a separate sheet with the rest of the codes.
Mod	Please enter modifier for the CPT code if applicable. If you have multiple modifiers for one CPT / HCPCS code please enter each modifier in a separate line.
Qty	Please enter number of units of service (or equipment / supplies) requested. For every CPT /HCPCS code you enter you are required to provide associated quantity.