Medical Prior Authorization Form

Please complete this form in its entirety. For a list of all services that require authorization, please refer to the following: www.cchpsc.org

Date: _____ Contact Person: _____

Telephone Number: _____ Fax Number: _____

Requesting Provider: _____ NPI_____ TIN_____

Servicing Provider: _____ NPI_____ TIN_____

Facility: _____NPI_____ TIN_____

Is the Servicing Provider In-Network? [ ] yes [ ] no

Member Name_____ Member ID Number_____

Member D.O.B._____

Type of service requested: _____

*Diagnosis Code(s): _____

*CPT/HPC Code(s):_____

*Date of Service: _____

Number of Visits: _____

Note: In order to process your request in a timely manner, please submit any pertinent clinical information to support the request for services. Please fax form to 855-258-5466.