Request for Prior Authorization

Effective: January 2023

COMMUNITY CARE HEALTH

Date:	Referral Coordinator:	From: ☐ Facility ☐ Provider
Phone:	Fax:	Intake:

Patient Information		
Patient Name:	DOB:	Phone:
Employee ID:	Address (Street, City, State Zip):	

Facility Information	
Facility Providing Services:	
Address (Street, City, State Zip):	
Phone:	TID:

Service Provider Information		
Physician Name:	Specialty:	
Address (Street, City, State Zip):		
Phone:	TID:	
Requested Service: Please provide at least one code in each of the following sections as well as a brief description of services requested		
ICD 10:		
CPT4 / HCPCS:		
Days:		Peer Contact:
Visits:		

PLEASE REMEMBER TO ATTACH ALL CURRENT/RELEVANT CLINICAL DOCUMENTATION.

Upon completion of the form you may submit your pre-certification request via fax to the primary line at (559) 243-7012 or the secondary line at (559) 499-1001. Download the **Prior Authorization CPT Code List** or visit Provider Resources at **www.communitycarehealth.org** for more information. For questions please call (855) 343-2247.

For Health Plan Use Only	
Group Name:	**Network:**
Reviewed By:	**Review Date:**
Approval #:	**DOS:**
Precert #:	**Denial Code:**
Savings:	**Savings Type:**
Billed Amount $:	**Comment:**