



# Request for Prior Authorization

Date:	Referral Coordinator:	From: <input type="checkbox"/> Facility <input type="checkbox"/> Provider
Phone:	Fax:	Intake:

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

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

Service Provider Information	
Physician Name:	Specialty:
Address (City, State Zip):	
Phone:	TID:
<b>Requested Service: Please provide at least one code in each of the following sections as well as a brief description of services requested</b>	
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 precertification request via fax to the primary line at (559) 243-7012 or the secondary line at (559) 499-1001. You may also download this form at [www.communitycarehealth.org/for-providers](http://www.communitycarehealth.org/for-providers). 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: