CONTRA COSTA HEALTH PLAN
A Division of Contra Costa Health Services

# PROCEDURE/SERVICES

**PRIOR AUTHORIZATION REQUEST**

**Fax Authorization Requests to CCHP**

Phone: (925) 957-7260 • Routine Fax: (925) 313-6058
Urgent Fax: (925) 313-6458 • CPAP Fax: (925) 313-6069

**ABA Fax: (925) 252-2626**

***Illegible or Incomplete forms will be returned***

| | |
|---|---|
| **Name:** | |
| **Member ID:** | |
| **DOB:** | |

**Date: _____**

☐ **If urgent, please check box and provide justification below.**
**INAPPROPRIATE USE WILL BE MONITORED.**

**Is condition:** ☐ Work related ☐ Retro ☐ Covered by CCS - **If yes,must obtain authorization from CCS.**
☐ Related to auto accident
**Date of Service: _____**

Secondary Carrier: _____
REQUESTING PROVIDER: _____
**Address: _____**
**Signature: _____**
How do we reach you if more information is needed?
**Phone: _____** | **Fax: _____**

If different from above, give the name of the person completing this form:

_____

**Referred to Provider/Vendor**: _____
Requested Specialty/Service:

If Medi-Cal Mental Health: ☐ **Mild/Moderate** ☐ **Severe**

**Phone: _____** | **Fax: _____**
**Address: _____**
**DX CPT: _____** **ICD-10: _____**
☐ **Initial Consult/Evaluation** ☐ **Procedure/Test**
☐ **Inpatient _____ days**
☐ **Follow-up _____ visits** ☐ **Other: _____**

**JUSTIFICATION** (Complete and send pertinent information, i.e. consult/progress note, test results, signs and symptom, etc.)

**Known Date of Service: _____**

**DO NOT USE THIS FORM FOR:**

- Bone Growth Stimulator
- TENS Unit
- Manual Wheelchair
- Motorized Wheelchair/ PowerOperated Vehicle
- Anti-Obesity Medication
- Gastric Surgery

*CALL THE AUTHORIZATION UNIT FOR APPLICABLE WORKSHEET*

**PRIOR AUTHORIZATION IS REQUIRED FOR (but not limited to):**

- Chemo/Radiation Therapy (not related to cancer), Cancer Clinical Trials
- Child Development Center, Craniofacial Clinic, Healthy Hearts (Children's Hospital Oakland)
- Dialysis
- Follow Up visits
- Home Health Services including Hospice & Home Infusion Therapy
- Inpatient admissions including OB, Acute Rehab, SNF & Hospice
- Neurosurgery Consult & Procedures
- Non-contracted providers & Tertiary Care
- Non-emergency Transportation
- DME, including Oxygen, Non-reusable Medical Supplies & Hearing Aids
- EMG, NCS & ENG
- Genetic or DNA testing
- Organ Transplant Evaluations
- Out-of-area services
- Outpatient Surgery and Facility based procedure
- PET Scans, Total Body Scans & Cardiac MRI
- Prosthetics, Appliances, Braces & Orthotics
- Psychiatry (M.D.) visits
- Referral of PCP to self for special services (e.g. surgery)
- RAST or MAST testing
- Rehabilitation services including Physical, Occupational, Speech Therapy&Cardiac or Pulmonary Rehab
- Services not available at CCRMC/HC
- Specialist referrals for RMCN: Initial & follow up visits
- Sub-specialty i.e. Pain Management, Urogyn, Weight Loss Clinic, Sleep Lab, etc.

Important Notice: Incomplete forms will be sent back for completion. Unauthorized, non-emergent, or non-urgent services rendered without prior authorization and/or after valid authorized dates are subject to payment denial.
Please allow CCHP the following turnaround time to make a decision **after receipt of reasonably necessary information: Standard: up to 5 business days • Urgent: up to 72 hours**

**AUTHORIZATION IS CONTINGENT UPON VERIFICATION OF ELIGIBILITY AT THE TIME OF ADMISSION OR AT THE TIME SERVICES ARE RENDERED.**

**PLEASE DO NOT WRITE IN THE SECTION BELOW • FOR CCHP/PCN USE ONLY**

☐ Approved: Authorization Number: _____ Effective Date: _____
☐ Modified: Approved per criteria#: _____ Effective Date: _____
☐ Denied: **Reason for Denial** _____
☐ Pt. not eligible HPAR/RN/MD Signature: _____

**MEDI-CAL MEMBERS may self-refer to Dental care by calling: (800) 322-6384 and self-refer for Mental Health services by calling (888) 678-7277** PA001 (02/2019)