REQUEST FOR PRIOR AUTHORIZATION

Effective: January 2025

COMMUNITY CARE HEALTH

IMPORTANT: Community Care Health will make a decision regarding a prior authorization request in a timely fashion appropriate for the nature of the member's condition, not to exceed **5 business days** from receipt of all necessary information ("routine review"). However, if the member is facing an imminent and serious threat to their health, the decision will be made within **72 hours** from receipt of all necessary information ("urgent review"). **The submitted records must substantiate the need for an urgent review.**

☐ **Routine** ☐ **Urgent**

Please complete the form in its entirety

Anticipated date of service:		**Service type:**	

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

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

Requesting Provider Information			
Provider:			
Address (Street, City, State, Zip):			
Phone:		Fax:	
TAX ID #:		NPI #:	

Service Facility / Provider Information			
Physician Name:		Specialty:	
Address (Street, City, State, Zip):			
Requested Service: Please provide at least one code in each of the following sections as well as a brief description of services requested			
Phone:		Fax:	
TAX ID #:		NPI #:	
ICD 10:			
CPT/ HCPCS:			
Days / Visits / Units			

Comments (Additional information, ICD, CPT/HCPC codes, price quote for DME items or attach it to this form)

PLEASE REMEMBER TO ATTACH ALL CURRENT/RELEVANT CLINICAL DOCUMENTATION.

***An authorization does not guarantee coverage and does not supersede any member benefit limits.**

Upon completion of the form you may submit your prior authorization request via fax to the primary line at (559) 724-4750 or the secondary line at (559) 724-4751. Download the **Prior Authorization CPT Code List** or visit Provider Resources at **www.communitycarehealth.org** for more information. For questions please call (559) 724-4995 or toll-free at 1-844-516-0181.