

**COOK CHILDREN'S HEALTH PLAN
Prior Authorization Request Form**

Care Management: 1-800-862-2247
Care Management Fax: 682-885-8402
Web Site: cookchp.com

Date Requested: _____
Type of Request: Routine Urgent Expedited Retro

SECTION 1: MEMBER/COVERAGE DATA

Name _____ DOB _____
ID# _____ PCP _____
Diagnosis _____ ICD-9 Code(s) _____

SECTION 2: PROVIDER DATA

A. REQUESTING PROVIDER

UPIN#(CHIP) _____ TPI#(STAR) _____ NPI#(CHIP/STAR) _____
Contact Name _____ Phone# _____ Fax# _____

B. SERVICE PROVIDER/FACILITY

Specialty _____
UPIN#(CHIP) _____ TPI#(STAR) _____ NPI# _____ Tax ID#(Facility) _____
Contact Name _____ Phone# _____ Fax# _____
Date of Service _____ Consult Only Visits # Requested _____ In-Network Yes No

SECTION 3:

***** All Out of Network Services Require CCHP Approval Before Services Are Provided*****

REQUESTED SERVICE(S)

Procedure/Service(s): _____ CPT Code(s): _____

- | | | |
|---|---|---|
| <input type="checkbox"/> Ambulance – air | <input type="checkbox"/> Ambulance - ground | <input type="checkbox"/> Office Procedures |
| <input type="checkbox"/> Assistant Surgeon/RNFA Name: _____ | | <input type="checkbox"/> Orthotics |
| <input type="checkbox"/> Dental Anesthesia/Facility | | <input type="checkbox"/> Outpatient Surgery |
| <input type="checkbox"/> Diagnostic Tests | | <input type="checkbox"/> Prosthetics |
| <input type="checkbox"/> Dialysis | | <input type="checkbox"/> Radiology |
| <input type="checkbox"/> Durable Medical Equipment | | <input type="checkbox"/> Therapies: <input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> ST |
| <input type="checkbox"/> Home Health | | Visits/Frequency _____ |
| <input type="checkbox"/> Injectables/Infusion Services | | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Inpatient _____ (Date) | | |
| <input type="checkbox"/> Observation _____ (Date) | | |

CLINICAL INFORMATION/ HISTORY/COMMENTS: [Attach Clinical Notes, Test Results, etc.]

SECTION 4: Approved Modified Approval [see attached letter] Denied [see attached letter]

Reference#/Units*/From-To: _____

THE ABOVE REFERENCE NUMBER DOES NOT GUARANTEE PAYMENT OF CLAIMS. PAYMENT OF CLAIMS IS SUBJECT TO THE MEMBER'S ELIGIBILITY AND TO THE CONTRACTUAL LIMITATIONS, PROVISIONS, AND EXCLUSIONS OF THE MEMBER'S BENEFIT PLAN.

COOK CHILDREN'S HEALTH PLAN PRIOR AUTHORIZATION REQUEST FORM COMPLETION GUIDE

❖ ****Note: Completely filled in information assists in the quick processing of your authorization request and claims.****

➤ **CCHP PRIOR AUTHORIZATION REQUEST FORM –**

- Enter date authorization is requested
- Check type of request [**based on medical need, not appointment time**]

➤ **SECTION 1: MEMBER/COVERAGE DATA – Enter:**

- member/patient name
- date of birth
- ID Number
- PCP [Primary Care Physician/Provider]
- Diagnosis and/or ICD-9 code(s)

➤ **SECTION 2: PROVIDER REQUESTING SERVICE; PROVIDER/FACILITY PROVIDING REQUESTED SERVICES – Enter:**

- *requesting provider's name [referred from]*
- check PCP or specialist [if specialist]
- provider's specialty
- contact person's name, phone and fax numbers
- *service provider's name [referred to] [enter "same" or leave blank if same as requesting provider]*
- specialty [if specialist]
- phone and fax numbers
- check the in network box yes or no
- *facility or ancillary provider name [referred to place of service]*
- date of service
- check the in network box yes or no
- check the consult only box or number of visits requested box [enter the number of visits requested]

➤ **SECTION 3: SERVICE INFORMATION – Enter:**

- procedure(s) and/or service(s) requested and CPT code(s)
- check box(es) for service(s) you are requesting
- enter and/or attach clinical information, history, comments
 - ✓ **SURGERY:**
 - enter Assistant Surgeon, RNFA name [If not on "Procedures Allowing Assistant Surgeons, RNFA" guidelines list]
 - enter Medical Necessity reason for Assistant Surgeon
enter names of surgeon and facility, etc [as listed above under SECTION 2]
 - enter/attach clinical information
 - ✓ **THERAPIES:**
 - check box(es) for therapy service(s) you are requesting
 - enter name(s) of therapy/service(s) on Procedure/Service line and/or CPT code(s)
 - enter number of visits, frequency and duration of therapy/service(s) on Procedure/Service line
 - enter/attach clinical information

➤ **SECTION 4: AUTHORIZATION RESPONSE – To be filled out by CCHP Care Management**

❖ ****Note: Completely filled in information assists in the quick processing of your authorization request and claims.****