Cook Children's Health Plan

Service Authorization Request Form

Phone: (682)885-2252; (888)243-3312 Fax: (682)885-8402

Authorization is a condition of reimbursement and is not a guarantee of payment. Payment of a claim is subject to a member's eligibility at the time services are provided and to the contractual limitations, provisions, and exclusions of the member's benefit plan. **An incomplete Service Authorization Request Form may delay processing of your request.**

***<u>Routine requests for authorization will be processed within three business days.</u> ***

Emergent (Service required for evaluation or treatment of an emergency medical condition within one hour.)

Urgent (Service required for evaluation or treatment of an urgent medical condition within one business day.)

Date:_____ **Name of Person Completing Form:**_____

Office Number:_____ **Fax Number:**_____

Member Name:_____ **Date of Birth:**_____

Member ID Number:_____ **Primary Care Provider:**_____

Requesting Provider Name:_____ **Req Provider NPI:**_____

Requesting Provider TPI (Medicaid)or UPIN/Tax ID (CHIP):_____

Facility/Service Provider Name:_____

Provider/Facility - NPI:_____ **- TPI (Medicaid) or UPIN/Tax ID (CHIP):**_____

Diagnosis:_____ **ICD-9 Code(s):**_____

Services/procedures you are requesting:_____

Dates of Service: From_________ **To**_________**Estimated inpatient Length of Stay**:_____

Medical history relevant to medical necessity for the requested service:_____

HCPCS/CPT Code(s)	Modifier	Visits/Units
1.	1.	1.
2.	2.	2.
3.	3.	3.
4.	4.	4.
5.	5.	5.

Place of Service

Inpatient	**Observation**
Outpatient	**Home**
Provider office	**Ambulatory Surgery**

(PLEASE DO NOT WRITE BELOW THIS LINE.)

Approved Denied Partial Denial Effective Date: From_____ To_____

Authorization Number:_____