REQUEST FOR PRIOR AUTHORIZATION FORM

WEBSITE SUBMISSIONS FOR REFERRALS - https://eznet.rchsd.org
Prior Authorizations FAX: 855-867-0868

NOTE: ALL FIELDS MUST BE COMPLETED IN ORDER TO PROCESS THE REQUEST WITHOUT DELAYS

Today's Date:	☐ Routine Referral	☐ Urgent Referral	☐ Retro DOS:

PATIENT INFORMATION			
Patient's Last Name:		First:	Middle:
CIN#	Birth Date: / /	Age:	Sex: M: ☐ F: ☐

REFERRING PROVIDER INFORMATION			
Referring Provider:			FAX:
PCP ☐	Specialist ☐	Location:	Phone:
Referring Physician Signature:			

REFERRED TO PROVIDER INFORMATION	
Referred **To** Provider:	Specialty:
No Provider Preference: ☐	
Refer **To** Facility:	

REASON FOR REFERRAL/ REQUEST FOR PRIOR AUTHORIZATION		
DIAGNOSIS:	**ICD10:**	
SERVICE REQUESTED:	**CPT:**	**UNITS:**
Medical Indication for Services:		
Supporting Documentation Attached: YES: ☐	*NO: ☐	* Referral cannot be processed without supporting clinical documentation

CONTACT INFORMATION	
Name of Person Submitting Referral:	
Office Location:	Phone :

Check Enrollment on Date of Service. Prior Authorization does not guarantee enrollment and is not a guarantee of payment if Member is not enrolled with CHA on date of service.

You may contact CHA to obtain access to the criteria that was utilized in making the determination for this request by calling the Prior Authorization Department at (800)387-1103. A copy of the specific section that was used in making the determination will be provided to you upon request.