CHOC HEALTH ALLIANCE

WHOLE CHILD MODEL

CCS ELIGIBILITY REQUEST

THIS DOCUMENT CONTAINS PHI

FAX COVER SHEET REQUIRED

Date: _____

Requester's Name: _____ Phone: _____

Member Information:

Member Name: _____ D.O.B: _____

CIN#: _____ ICD-10 Diagnosis: _____

Medical Eligibility Request:

□ Initial Request

□ Required Attachments:

- □ New CCS Referral or GHPP Client Service Authorization Request (SAR)
- □ Member's medical records

*Submit all documents to CCS@choc.org or fax to 714-628-9178