CHOC HEALTH ALLIANCE

REQUEST FOR PRIOR AUTHORIZATION FORM

WEBSITE SUBMISSION - 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 ☐ Retro – Date(s) of Service: _____ ☐ Urgent – **ONLY** for use when the standard 5-day process would seriously jeopardize the life or health of the member.

PATIENT INFORMATION

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

REQUESTING PROVIDER INFORMATION

Referring Provider:			FAX:
PCP ☐	Specialist ☐	Location:	Phone:

REQUESTED PROVIDER INFORMATION

Referred **To** Provider:	Specialty:
Refer **To** Facility:	

SERVICES REQUESTED

DIAGNOSIS:	**ICD10:**	
SERVICE REQUESTED:	**CPT:**	**UNITS:**

Medical Indication for Services:

Supporting clinical documentation must be attached to avoid delays in processing.

CONTACT INFORMATION

Name of Person Submitting/Office Name:	
Phone:	Fax:

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.