



## Medicaid Out of Network Prior Authorization Request Form

**Paper Claims Submission:**  
**Chorus Community Health Plan**  
**PO Box 56099**  
**Madison, WI 53705**  
**1-800-482-8010**

**Clinical Services**  
**Phone: 877-227-1142**  
**Fax: 414-266-4726**

- All in-network providers must use GuidingCare on the CCHP Provider Portal to submit their requests.
- Requests for out-of-network providers must be approved by CCHP's Utilization Management department before providing services.
- An approved request does not authorize payment of non-covered or exhausted benefits.
- All fields are required.
- Sanctions Form must be returned within 24 hours to consider this a complete request – incomplete requests may be rejected.

|                           |                  |
|---------------------------|------------------|
| UM Clinical Contact Name: | UM Phone Number: |
| UM Contact Email:         | UM Fax Number:   |

### Member Information (all sections must be completed or it will be returned without review)

|              |  |                       |  |
|--------------|--|-----------------------|--|
| Member Name: |  | Member ID Number:     |  |
| Address:     |  | Member Date of Birth: |  |
| City:        |  | State:                |  |
| Phone:       |  | Zip Code:             |  |

### Referring Provider Information

|               |  |                  |           |
|---------------|--|------------------|-----------|
| Name:         |  | Phone Number:    |           |
| Address:      |  | Fax Number:      |           |
| City:         |  | State:           | Zip Code: |
| Provider NPI: |  | Provider Tax ID: |           |

### Service Facility Information

|               |  |                  |           |
|---------------|--|------------------|-----------|
| Name:         |  | Phone Number:    |           |
| Address:      |  | Fax Number:      |           |
| City:         |  | State:           | Zip Code: |
| Facility NPI: |  | Facility Tax ID: |           |

### Service Provider Information

|               |  |                  |           |
|---------------|--|------------------|-----------|
| Name:         |  | Phone Number:    |           |
| Address:      |  | Fax Number:      |           |
| City:         |  | State:           | Zip Code: |
| Provider NPI: |  | Provider Tax ID: |           |
| Specialty:    |  |                  |           |

## Required Information for out-of-network referrals

|                                                             |  |                        |  |
|-------------------------------------------------------------|--|------------------------|--|
| List of in-plan providers that the member has already seen: |  |                        |  |
| Reason care cannot be provided in-network:                  |  |                        |  |
| Diagnosis code(s):                                          |  | Diagnosis description: |  |
| Start Date:                                                 |  | End Date:              |  |

## Service(s) Requested: Check one box below

☐ Urgent Request

|                          |                              |                          |              |
|--------------------------|------------------------------|--------------------------|--------------|
| <input type="checkbox"/> | Medical Inpatient            | <input type="checkbox"/> | Hospice      |
| <input type="checkbox"/> | Observation                  | <input type="checkbox"/> | Home Care    |
| <input type="checkbox"/> | Medical Outpatient           | <input type="checkbox"/> | Dialysis     |
| <input type="checkbox"/> | Behavioral Health Inpatient  | <input type="checkbox"/> | DME Rental   |
| <input type="checkbox"/> | Behavioral Health Outpatient | <input type="checkbox"/> | DME Purchase |
| <input type="checkbox"/> | Transplant Service           | <input type="checkbox"/> | Pharmacy     |

## Include all CPT/HCPCS codes and number of visits/units for each code requested

| Number of visits/units | CPT / HCPCS code | Number of visits/units | CPT / HCPCS code |
|------------------------|------------------|------------------------|------------------|
|                        |                  |                        |                  |
|                        |                  |                        |                  |
|                        |                  |                        |                  |
|                        |                  |                        |                  |
|                        |                  |                        |                  |
|                        |                  |                        |                  |
|                        |                  |                        |                  |
|                        |                  |                        |                  |



## Out of Network Facility Sanction Request

**\*\*All information is required in order to process your pre-authorization request and held secure and confidential.**

Dear Provider

Thank you for your request for service of our member. In order to process your request please complete and return this form via fax to Chorus Community Health Plans. Sanctions Form must be returned within 24 hours to consider this a complete request – incomplete requests may be rejected. Only complete requests will be processed for review.

Name of Organization

---

Type of Organization

---

Address 

---

City 

---

 State 

---

 Zip Code 

---

Are you a Medicaid Provider      Yes    No

NPI 

---

Taxpayer Identification Number 

---

Please fax completed form to: **414-266-4726**