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 the CareWebQI Authorization tool 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.

☐URGENT

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:	
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:					

CHORUS COMMUNITY HEALTH PLANS

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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

Must include all CPT/HCPCS codes and number of visits/units for each code requested.

☐Medical Inpatient ☐Observation ☐Medical Outpatient ☐Behavioral Health Inpatient ☐Behavioral Health Outpatient

☐Transplant Service ☐Hospice ☐Home Care ☐Dialysis ☐DME Rental ☐DME Purchase ☐Pharmacy

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 Children's Community Health Plan. 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**