SERVICE AUTHORIZATION FORM

This form must be completed in its entirety. Failure to do so may delay processing and result in service denial.

Fax to CCHP at (415) 398-3669

All out of network, UCSF Medical Group, Stanford Hospital and Clinics, Lucile Packard Children's Medical Group and Sutter Pacific Medical Foundation Providers must be pre-authorized before service is provided.

Member Information

☐ Commercial	☐ Senior	☐ SFHP
☐ Covered California	☐ Senior Value	☐ Anthem BC Commercial
	☐ Senior Select	

First Name:	Member ID#:
Last Name:	Date of Birth: Gender: ☐ **M** ☐ **F**

Check only one request type:

☐ Urgent Request ☐ Non-Urgent Request ☐ Standing Referral ☐ Retroactive DOS:________

Check only one service type:

☐ Consultation	☐ Follow-up	☐ Outpatient	☐ Inpatient
☐ Diagnostic	☐ DME	☐ Home Health	☐ Other: ____________

Description of Requested Service	CPT/HCPCS/NDC	Unit(s) Requested	Health Plan Use Only Unit(s) Approved
1.			
2.			
3.			
4.			
5.			

Diagnosis:	Diagnosis:
ICD-10:	ICD-10:

Medical Justification/Necessity: Please attach progress notes or supporting documentation (e.g. labs, X-ray)

Service Provider Information

First Name:	Telephone #: ( )
Last Name:	Fax #: ( )
	Email:
Address:	City: Zip Code:

Note: This member was referred to you by an in-network provider. If more visits or treatment is needed, please complete a Service Authorization Form and fax it to CCHP. Provider must check eligibility with two (2) business days prior to services. All providers of services to this patient agree to accept Jade Health Care and/or CCHP rates as payment in full. For web-based inquiry, please visit www.cchphealthplan.com > For Providers > Eligibility Inquiry > Web Based Inquiry.

Requesting Provider Information

First Name:	Telephone #: ( )
Last Name:	Fax #: ( )
Signature:	**Date:**

Health Plan Use Only	Authorization #:
Received Date:	☐ Approved ☐ Denied ☐ Modified
Received/Processed By:	Decision by:
Returned Date	Decision Date:
Case #:	From: To:

To the best acknowledgement, I have the scope of licensure or certification that typically manages the medical condition, procedure, treatment, or issue under review and I have the current relevant experience and/or knowledge to render a determination for the case under review. Initials___

Confidentiality Statement: This authorization is intended for the sole use of the addressee(s). The information may contain privileged or otherwise confidential information and is protected from disclosure by law. If you receive this in error, please destroy and notify CCHP at 1-877-208-4959. rev20201022

General Information

This authorization does not authorize the provision of services in excess of those benefits currently provided under the member's service agreement for services to be covered. The member must be enrolled at the time the service is provided.

Referrals to Sutter Pacific Medical Foundation, Stanford Hospital and Clinics, Lucile Packard Children's Medical Group or UCSF Medical Center for tertiary care services will require pre-authorization. A Service Authorization Form (SAF) is required.

To The Provider

1. This authorization is limited to the care and/or treatment for the stated diagnosis or problem. If care or treatment other than/in addition to that which is authorized herein is required (including hospital or other institutional care or consultation) by non-Jade Health Care or non-CCHP physicians, additional authorization is needed prior to obtaining or rendering such care or treatment unless it is emergent. Any additional services requiring authorization must be requested with a completed and signed Service Authorization Form (SAF) and faxing it to the CCHP Utilization Management Department at (415) 398-3669.

2. Jade Health Care and CCHP providers may refer to Jade Health Care and/or CCHP physicians for up to four (4) visits in a calendar year for the same diagnosis. Any additional visits (≥5) require authorization with a SAF and faxing it to the CCHP Utilization Management Department at (415) 398-3669.

3. Unless otherwise indicated this referral is valid for the calendar year only. If an extension is needed, contact the referring physician or the CCHP Utilization Management Department at (877) 208-4959 for additional information.

4. The member has agreed to receive referral services from Jade Health Care or CCHP. The health professional accepting this member agrees to seek payment of covered services only from the medical group or plan and agrees not to bill the member.

5. If there is any question concerning this authorization, please call Utilization Management at (877) 208-4959.

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