REFERRAL AND SERVICE REQUEST FORM INSTRUCTIONS"

If the patient requires urgent services, please contact us by telephone at 1-888-484-1412. Urgent Services are services that are required to prevent serious deterioration of health following the onset of an unforeseen condition or injury and has the potential to become an emergency in the absence of treatment. A condition is urgent when our routine timeframe for making a determination would be detrimental to the patient's life or health or could jeopardize his/her ability to regain maximum function.

All services require prior authorization **except** the following:

- Emergency services and out-of-Service Area urgent services
- Services designated as "sensitive services" or "freedom of choice" by the Medi-Cal program including
    - family planning
    - treatment of sexually transmitted disease (STD)
    - Human immunodeficiency virus (HIV) testing
    - routine OB/GYN services and basic prenatal care through network practitioners
- Services listed on CHPIV's "Services That Do Not Require Prior Authorization" published in CHPIV's Provider Manual

Billing Instructions:

Claims for services should be submitted within 120 days from the date of service by using the Electronic Claims Submission (EDI) to responsible party. IPA contact information and CHPIV clearinghouse information is posted on our website: Provider Resources - Community Health Plan of Imperial County | Medicare Advantage Plus Plan

Paper claims that are CHPIV responsibility should be mailed to:

CHPIV Community Advantage Plus
Claims Department #53
P.O. Box 210700, Chula Vista CA 91921

All claims must be submitted on a CMS 1500 or UB92 and include:

- Patient's name
- Social security number
- Patient's zip code
- Diagnosis
- Procedure code
- Billed Amounts
- Date of birth
- Health Plan authorization number
- Date of service
- Name of facility / provider when applicable
- Tax ID

Please contact Provider Services at chpivprov@chgsd.com for claims or billing questions.

Community Health Plan
OF IMPERIAL VALLEY | ADVANTAGE PLUS

REFERRAL AND SERVICE REQUEST FORM

PHONE 1-888-484-1412 **FAX 1-800-870-8781**

☒Routine ☐Urgent

Referral is considered **"Urgent"** when the member's life, health or ability to regain maximum function is seriously jeopardized, based on the prudent layperson's judgment or when the patient's practitioner determines that the member would be subjected to severe pain that cannot be adequately managed without the care that is being requested.

Please fill out this form legibly and completely. Incomplete requests may be returned.
Updated clinical documentation is required.

Today's Date: ☐**Medicare** ☐**Medi-Cal**

Patient's Name: ID#: DOB:

Current: Address:

Telephone Number: Alternate Telephone Number:

Type of Referral or Service Requested:	
☐Outpatient ☐Inpatient☐Home Health	Primary diagnosis **ICD-10** code: _____
☐DME ☐ In-Office Procedure	Secondary diagnosis ICD-**10** code: _____

Specialty Type:	Contracted Provider Being Requested: Phone # Fax #	Facility or Vendor:

Description of service(s) requested:	**CPT** or **HCPCS** codes (To avoid denial or rejection please ensure codes are a benefit at time of request)	Number of Units

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(Complete information needed for timely processing)

Referring Provider: _____ **Office Contact:**_____

Phone Number (ext.): _____ **Fax#**_____

Determination will be based on eligibility and plan benefits at the time services are rendered.

PLEASE DO NOT RESUBMIT REFERRAL UNLESS INSTRUCTED BY CHPIV