



## 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
- Please note the following regarding California Children Services (CCS):
  - CHPIV will accept a completed CCS Application in place of our Referral and Service Request Form
  - You do not have to submit a request when you are aware that the requested service is related to a condition for which the member has an open CCS case and the provider of service is linked to that case.
  - CCS services must be provided by a CCS-paneled provider and requested prior to services being rendered.
- Billing Instructions:
  - Claims for services should be submitted within 120 days from the date of service by using the Electronic Claims Submission (EDI) or in paper form to:  
If you are interested in submitting EDI, please contact our EDI manager.

Community Health Plan of Imperial Valley  
P.O. Box 174  
Imperial, CA 92251

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

- patient's name	- date of birth
- social security number	- CHG authorization number
- patient's zip code	- date(s) of service
- diagnosis	- name of facility / Provider (when applicable)
- procedure code	- Tax ID
- Billed Amounts	
- Please call CHG's Provider Services Unit at [chpivprov@chgsd.com](mailto:chpivprov@chgsd.com) for claims or billing questions.



## REFERRAL AND SERVICE REQUEST FORM

PHONE 1-888-484-1412

FAX 1-760-457-3008

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. For CCS cases, provide completed copy of CCS application.**

Today's Date: \_\_\_\_\_

CCS

Medi-Cal

Medicare

Patient's Name: \_\_\_\_\_

ID#: \_\_\_\_\_

DOB: \_\_\_\_\_

Current Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Alternate Telephone Number: \_\_\_\_\_

**Type of Referral or Service Requested:**

Outpatient Health

Inpatient

Home

DME

In-Office Procedure

Primary diagnosis ICD-10 code: \_\_\_\_\_

Secondary diagnosis ICD-10 code: \_\_\_\_\_

Specialty Type: \_\_\_\_\_

Contracted Provider Being Requested: \_\_\_\_\_

Facility or Vendor: \_\_\_\_\_

Phone # \_\_\_\_\_

Fax # \_\_\_\_\_

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



# Community Health Plan

OF IMPERIAL VALLEY | ADVANTAGE PLUS

**(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.**

The information contained in this facsimile is confidential and may also contain privileged client information or work products. The information is intended only for the use of the individual or entity to whom it is addressed. If you are not the intended recipient, or the employee or agent responsible to deliver it to the intended recipient, you are hereby notified that any use, dissemination, distribution, or copying of this communication is strictly prohibited. If you have received the facsimile in error, please immediately notify us by telephone, and return the original message to us at the address below via the U. S. Postal Service. Thank you.

**PLEASE DO NOT RESUBMIT REFERRAL UNLESS INSTRUCTED BY CHPIV**