



# CHOC HEALTH ALLIANCE

## REQUEST FOR PRIOR AUTHORIZATION FORM

WEBSITE SUBMISSIONS FOR REFERRALS - <https://eznet.rchsd.org>

Prior Authorizations FAX: 855-867-0868

**NOTE: ALL FIELDS MUST BE COMPLETED IN ORDER TO PROCESS THE REQUEST WITHOUT DELAYS**

<b>Today's Date:</b>		<input type="checkbox"/> Routine Referral	<input type="checkbox"/> Urgent Referral	<input type="checkbox"/> Retro DOS:
PATIENT INFORMATION				
Patient's Last Name:		First:	Middle:	
CIN#	Birth Date: / /	Age:	Sex: M: <input type="checkbox"/> F: <input type="checkbox"/>	
REFERRING PROVIDER INFORMATION				
Referring Provider:			FAX:	
PCP <input type="checkbox"/>	Specialist <input type="checkbox"/>	Location:	Phone:	
Referring Physician Signature:				
REFERRED TO PROVIDER INFORMATION				
Referred To Provider: Dr. Patricia Riba			Specialty: Pediatrics/Obesity	
No Provider Preference: <input type="checkbox"/>				
Refer To Facility: Dr. Riba's Health Club				
REASON FOR REFERRAL/ REQUEST FOR PRIOR AUTHORIZATION				
DIAGNOSIS: Obesity			ICD10: E66.9	
SERVICE REQUESTED:			CPT:	UNITS:
99205 (1)				(1)
99215 (8)				(8)
Medical Indication for Services: Refer to Dr. Riba's Health Club				
Supporting Documentation Attached: YES: <input type="checkbox"/> *NO: <input type="checkbox"/> * Referral cannot be processed without supporting clinical documentation				
CONTACT INFORMATION				
Name of Person Submitting Referral:				
Office Location:			Phone :	

Check Enrollment on Date of Service. Prior Authorization does not guarantee enrollment and is not a guarantee of payment if Member is not enrolled with CHA on date of service.

You may contact CHA to obtain access to the criteria that was utilized in making the determination for this request by calling the Prior Authorization Department at (800)387-1103. A copy of the specific section that was used in making the determination will be provided to you upon request.



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Referred To Provider:		Specialty:		
No Provider Preference: <input type="checkbox"/>				
Refer To Facility:				
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