

# Prior Authorization Request Form



**COMMUNITY HEALTH PLAN**  
of Washington™

**Community HealthFirst™**  
Medicare Advantage Plans

**For Apple Health Plans:**

Prior Authorizations requests may be faxed to:  
**(206) 613-8873**

Please call Customer Service to verify eligibility & benefits:  
**1-800-440-1561;**  
**Monday through Friday,**  
**8 a.m. - 5 p.m.**

**For Medicare Advantage Plans:**

Prior Authorizations requests may be faxed to:  
**(206) 652-7065**

Please call Customer Service to verify eligibility & benefits:  
**1-800-942-0247;**  
**Seven days a week, 8 a.m. - 8 p.m.**

- A complete list of services requiring Prior Authorization may be found at [www.chpw.org](http://www.chpw.org)
- Prior Authorization requests may be made through the Medical Management Portal at [www.chpw.org/submitcare](http://www.chpw.org/submitcare).
- **Please attach supporting clinical documentation to this fax.**
- Incomplete forms and requests without clinical information will delay processing
- A Prior Authorization is not a guarantee of payment; Payment is subject to member eligibility and benefits at the time of service

<b>ORDERING PROVIDER INFORMATION</b>				
First Name:		Last Name:		Contact Phone #:
				Contact Fax #:
Contact Person at this office:		<input type="checkbox"/> Ordering provider is PCP PCP's Clinic Name:		<input type="checkbox"/> Ordering provider is Specialist Specialty:
<b>PATIENT INFORMATION</b>				
First Name:		Last Name:		MI: Date of Birth:
CHPW Member ID:				
<b>SERVICE PROVIDED BY</b>				
First Name:		Last Name:		Address:
<input type="checkbox"/> Participating <input type="checkbox"/> Non-Participating	Tax ID:	Specialty:	Contact Phone #:	Contact Fax #:
Facility Name:			Address:	
<input type="checkbox"/> Participating <input type="checkbox"/> Non-Participating	Tax ID:	Contact Phone #:	Contact Fax #:	
<input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient			Please indicate <b>CLINICAL</b> urgency of request: <input type="checkbox"/> Routine <input type="checkbox"/> Urgent	
Diagnosis: Primary: Code (_____) Description: _____			Date of Service:	
Secondary: Code (_____) Description: _____				
Services being requested:			<input type="checkbox"/> New request <input type="checkbox"/> Extension	
CPT /HCPCS #1 _____	Description: _____		Request*	
CPT /HCPCS #2 _____	Description: _____		# Visits: _____ Duration: _____	
CPT /HCPCS #3 _____	Description: _____		*Last Date of service if an extension _____	