CCHP – Authorization/Referral Request

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Notice: In accord with the Colorado Choice Health Plans/SLVHMO (Colorado Choice) Member, all referrals (other than on an emergency basis) must be sent by participating providers and be approved in advance by the CCHP Medical Director. Care must be completed within the time period indicated. Notification of emergency referrals must be submitted to the CCHP Medical Director within 48 hours after referrals are made. Referral requests received more than 10 business days after the service was provided with be denied.
This authorization is limited to the care/treatment indicated for the stated diagnosis/problem. Approval of this request for referral authorization does not authorize the provision of services in excess of those benefits currently provided under the member's service agreement with Colorado Choice. For services to be covered, the member must be enrolled at the time the service is provided. Payment is subject to verification of eligibility w/in 2 business days prior to the delivery of services. Colorado Choice verification of eligibility is made based upon records at hand. Payment for this claim will not be made if member's premium has not been paid to Colorado Choice for the period in which the date of service occurs. Colorado Choice will pay the contracted fee or an amount not to exceed usual/ customary/reasonable charges. Specialty care provider agrees to accept Colorado Choice payment as payment in full (except for applicable deductible/copayment/coinsurance) and holds harmless the member for any amount owed by Colorado Choice

Incomplete requests will be returned. In order to be considered for review, requests must be legible and must include the following:

1) A completed copy of the CCHP Request for Authorization/Referral Request form (below),
2) Clinical dictation &/or supporting documentation relating to requested service(s),
3) The referring physician's signature/E-signature or written signed order

Patient/Member Information

Name: _____
DOB: _____ CCHP ID #: _____
Other Insurance? ☐ Yes ☐ No If Yes, Information:
_____
Is the requested service work related? ☐ Yes ☐ No
Is the requested service auto related? ☐ Yes ☐ No

Whom should we contact if we have follow up questions?
Name: _____
Phone: _____ Fax: _____

Referring Physician/Provider Information

Name: _____
Tax ID#: _____
Phone: _____ Fax: _____
Address: _____

Referring to (hospital/surgical center/imaging center)
Facility: _____
Tax ID#: _____
Phone: _____ Fax: _____
Address: _____

Referring to (If different than the referring)
Provider: _____
Tax ID#: _____
Phone: _____ Fax: _____
Address: _____

Service(s) being requested (Brief description with associated codes)

Brief Description **Check if: ☐ Inpatient or ☐ Outpatient**	CPT/HCPCS	ICD-10	DOS[1]

Doctor's Signature _____ Date _____

[1] Enter all service dates scheduled

The results of the care of treatment rendered by the specialty care provider under this referral authorization must be forwarded to the CCHP referring physician named for inclusion in the patient's medical record. Authorization is not required for in-network specialist office visits billed alone. If additional services are performed during visit, authorization may be required. For plan w/ out-of-network benefits, a prior authorization is not required for office visits, whether in- or out-of-network.