california health & wellness

Fax to: 855-556-7909

CBAS TREATMENT REQUEST FORM

If you have questions about how to complete this from, please call California Health & Wellness at 1-877-658-0305 and ask for Case Management.

X Requesting Provider/CBAS Representative Signature

Name (print) Date (MMDDYYYY)

☐ Expedited Request - Please check if this is for a new participant who is hospitalized or anticipated to be admitted to a Skilled Nursing Facility.

*** *INDICATES REQUIRED FIELD***

MEMBER INFORMATION

Member Phone Number *

Date of Birth * (MMDDYYYY)

Member ID/Medi-Cal ID *

Last Name, First

PROVIDER/CBAS FACILITY INFORMATION

Requesting Provider/CBAS Facility NPI *

Requesting Provider/CBAS Facility TIN

Provider/CBAS Facility Contact Name

Requesting Provider/CBAS Facility Address

City

Zip Code

Requesting Provider/CBAS Facility Name

Phone

Fax

AUTHORIZATION REQUEST

Start Date (MMDDYYYY)

End Date (MMDDYYYY)

Quantity per Month

SERVICES ◊

Face to Face Assessment (T1023)

☐ Initial
☐ Modification

Individual Plan of Care (IPC) Evaluation (H2000)

☐ Initial
☐ Continuation ◊
☐ Modification

Medical Day Care Services (S5102)

☐ Initial
☐ Continuation ◊
☐ Modification

Attach copy of H&P with request.

◊ **Please attach the IPC and participant attendance records for continued authorization requests.**

ALL REQUIRED FIELDS MUST BE FILLED IN AS INCOMPLETE FORMS WILL BE REJECTED.
COPIES OF ALL SUPPORTING CLINICAL INFORMATION ARE REQUIRED. LACK OF CLINICAL INFORMATION MAY RESULT IN DELAYED DETERMINATION.

Disclaimer: Please check member eligibility prior to rendering services. A prior authorization is not a guarantee of payment. Payment may be denied in accordance with Plan's policies and procedures and applicable law.

Rev. 11 21 2014
CA-PAF-0774