



## REFERRAL AND SERVICE REQUEST FORM INSTRUCTIONS

- If the patient requires urgent services, please contact us by telephone at (619) 498-6400. 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 CHG's "Services That Do Not Require Prior Authorization" published in CHG's Provider Manual
- Please note the following regarding California Children Services (CCS):
  - CHG 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.
  - We will issue a tracking number after we have reviewed a potential CCS case. This tracking number indicates that the request has met CHG's medical necessity criteria.
  - CCS services must be provided by a CCS-paneled provider and requested prior to services being rendered. Services will not be retroactively approved for Healthy Families members, in accordance with state regulations.
- Billing Instructions:
  - Claims for services should be submitted within 120 days from the date of service to:

Community Health Group <b>Medi-Cal Claims</b> P.O. Box 1237 Chula Vista, CA 91912	Community Health Group <b>Statistical/Encounter Claims</b> P.O. Box 1267 Chula Vista, CA 91912
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  - Community Health Group  
**Healthy Families Claims**  
P.O. Box 1236  
Chula Vista, CA 91912
  
  - All claims must be submitted on a HCFA 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 (619) 498-6498 for claims or billing questions.



REFERRAL AND SERVICE REQUEST FORM

<p><b>CHG Use Only</b> Data Entry #:</p>
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PHONE 1-800-945-5570 OR (619) 498-6400

FAX (619) 425-5348

**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  Healthy Families  Medicare

Patient's Name: \_\_\_\_\_ ID#: \_\_\_\_\_ DOB: \_\_\_\_\_

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

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

Type of Referral or Service Requested:  Inpatient  Outpatient  DME  In-Office Procedure  
 What is the primary diagnosis or ICD-9 code? \_\_\_\_\_  
 secondary diagnosis (**mandatory**) ICD-9 code? \_\_\_\_\_

What is the reason for this referral or service request? (appropriate documentation, **must** be submitted with request)

Specialty Type:	Referral to Contracted Provider: provide name here Phone # _____ Fax # _____	Facility or Vendor: provide name here
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Describe the service(s) requested:	(16) What are the CPT or HCPCS codes? ( <b>mandatory</b> )	(17) What are the number of units requested?

**(Mandatory information needed for timely processing)**  
 Referral sent by: \_\_\_\_\_ Office Contact \_\_\_\_\_  
 Phone Number (ext.): \_\_\_\_\_ Fax# \_\_\_\_\_

Approved <input type="checkbox"/>	By _____ Date: _____	<b>COMMENTS:</b>
Modified <input type="checkbox"/>		
Denied <input type="checkbox"/>		

**\*The tracking number is not a guarantee of payment. 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 product. 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 CHG**