CHP REFERRAL / PRECERTIFICATION REQUEST FORM

CorrectionalHealthPartners

1720 S Bellaire St.Suite 700
Denver, CO 80222

CHP Medical Management
Phone: 1-866-362-1374 Option 2
Fax: 1-866-362-1375

Date of request:______________

Offender

Last Name________________________ First Name____________________________
Offender ID_______________________

Gender ☐ Male ☐ Female DOB________________________________
Facility ____

Priority Level _________________________ **Custody Level** _______________________

Request

Request Type (*check one*):

- ☐ Ambulatory Surgery
- ☐ DME (Durable Medical Equipment)
- ☐ Office Visit
- ☐ Other ______________________________
- ☐ Inpatient
- ☐ Observation
- ☐ Therapy (PT/OT/ST/Card Rehab)
- ☐ Pharmacy
- ☐ Surgical Assistant (SA)
- ☐ Outpatient Diagnostic

Requesting Provider

Name_____________________________ Contact_______________________________
Phone___________________________ Fax__________________________________

Refer to Provider

Name___________________________________
Phone______________________________ Fax__________________________________
Surgical Assist_______________________ Facility______________________________

Clinical

DOS ______________
ICD-9 1.____________2.________________3.________________4.____________
CPT 1.____________2.________________3.________________4.____________

Supporting Medical Information (Criteria for Surgery / DME / What is the provider trying to rule out? / Past tx, history (therapies, etc.) / Test results (radiological evidence, etc.):

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This precertification is not a guarantee of payment. Coverage will be determined based on medical necessity, eligibility, policy provisions and availability of remaining benefits, at the time of service.

Effective 9/1/05
Reviewed 08/2013