



CBAS TREATMENT REQUEST FORM

Fax to:1-833-581-5908

If you have questions about how to complete this form, please call Health Net at 1-866-801-6294, select option 1 to speak with a Referral Specialist.

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 Telephone Number *

Date of Birth *

MEMBER INFORMATION

Member ID/Medi-Cal ID *

Last Name, First

(MMDDYYYY)

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

Telephone

Fax

AUTHORIZATION REQUEST (S5102)

Start Date

End Date

Quantity per Month

Diagnosis Code *

(MMDDYYYY)

Start Date

(MMDDYYYY)

End Date

Quantity per Month

(ICD-10)

Diagnosis Code *

(MMDDYYYY)

Start Date

(MMDDYYYY)

End Date

Quantity per Month

(ICD-10)

Diagnosis Code *

(MMDDYYYY)

Start Date

(MMDDYYYY)

End Date

Quantity per Month

(ICD-10)

Diagnosis Code *

(MMDDYYYY)

Start Date

(MMDDYYYY)

End Date

Quantity per Month

(ICD-10)

Diagnosis Code *

(MMDDYYYY)

Start Date

(MMDDYYYY)

End Date

Quantity per Month

(ICD-10)

Diagnosis Code *

(MMDDYYYY)

(MMDDYYYY)

(ICD-10)

SERVICES *

3-Day Individual Plan of Care (IPC) Assessment for New CBAS (H2000)

Modification² (Increase/Decrease)

Face-to-Face Assessment (T1023)

Initial

Reinstate Services

Initial

Medical Day Care Services (S5102)

Transfer

Modification

Initial

² Please attach copy of History and Physical (H&P) with Face to Face Assessment request.

Continuation/Renewal²

² Please attach IPC, participant attendance records and transfer reason (if applicable) for continued authorization requests.

ALL CBAS REQUESTS REQUIRE COMPLETION OF THIS FORM. ALL REQUIRED FIELDS MUST BE FILLED IN. 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.

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CA-PAF-CBAS

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