Fax to:1-833-581-5908

CBAS TREATMENT REQUEST FORM

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 INFORMATION

Member Telephone 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

Telephone

Fax

AUTHORIZATION REQUEST (S5102)

Start Date (MMDDYYYY)	End Date (MMDDYYYY)	Quantity per Month	Diagnosis Code * (ICD-10)

SERVICES *

Face-to-Face Assessment (T1023)

☐ Initial

☐ Modification

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

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

☐ Initial

Medical Day Care Services (S5102)

☐ Initial

☐ Continuation/Renewal[2]

☐ Modification[2] (Increase/Decrease)

☐ Reinstate Services

☐ Transfer

[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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