CBAS TREATMENT REQUEST FORM

If you have questions about how to complete this Community-Based Adult Services (CBAS) Request Form, please call Health Net at 800-526-1898, and select option 1 to speak with a Referral Specialist. **Submit completed form via fax to 833-581-5908.**

☐ **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* (MM/DD/YYYY)

Member ID/Medi-Cal ID*

Last name*

First name*

Provider/CBAS facility information

Facility NPI*

Facility TIN

Contact name

Facility address

City

ZIP code

Facility name

Phone

Fax

Authorization request (S5102)

Start date (MM/DD/YYYY)	End date (MM/DD/YYYY)	Quantity per month	Diagnosis code (ICD-10)*

Services*

Face-to-face assessment (T1023)

☐ Initial

☐ Modification

Please attach copy of history and physical with face-to-face assessment request.

3-day individual plan of care (IPC) assessment for new CBAS (H2000)

☐ Initial

☐ Modification

Medical day care services (S5102)

☐ Initial

☐ Continuation/Renewal[1]

☐ Modification[1] (Increase/Decrease)

☐ Reinstate services

☐ Transfer

[1]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.

Requesting provider/CBAS representative

Name (print): _____ Date: _____

Signature: _____

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 the Plan's policies and procedures and applicable law.

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