CHAIN – Medical Subspecialty Services Referral and Authorization Request

Instructions

Prior authorizations are required for referrals to specialists participating in the CHAIN Program and all covered procedures and medical services. **Providers and facilities must be in network. Referrals and procedures must be related to HIV- or AIDS-related conditions.** See the CHAIN – Medical Subspecialty Services Referral Program *Provider Information* publication for more information about covered and excluded services. See the *Provider Directory* for network providers.

Authorization Request Instructions

Complete this form and fax it **along with CaseWatch® screen shots to demonstrate patient eligibility and supporting physician progress notes and/or ancillary data** to Utilization Management at (888) 238-2337. Routine authorization requests are rendered within five (5) days; urgent requests are rendered within 72 hours. Please call (866) 644-5025 for authorization status. Claim(s) will be paid if a prior authorization has been granted.

Excluded Services

- Acupuncture
- Chemotherapy
- Chiropractic
- Dental Care
- Emergency Care
- Holistic Health
- Home Health Services
- Hospice
- Inpatient Services
- Medical Supplies
- Mental/Behavioral Health
- Obstetrics
- Oncology *(Some exemptions apply, see "Provider Information" publication for details)*
- Pediatrics
- Prescription Drugs
- Primary and Routine Care
- Rehabilitation Services
- Sleep Medicine
- Substance Abuse or Addition Treatment
- Transportation
- Vision Care

Date of Request _____ Check if Urgent ☐

Patient Information

_____ _____ _____
Patient Name | CaseWatch Patient ID Number | Birth Date

_____ _____
Phone Number | Patient Address

_____ _____ _____ _____
Primary Care Provider Name | Contact | Phone | Fax

Referring Provider Information

_____ _____
Provider Name | Clinic Name

_____ _____ _____
Contact | Phone | Fax

Indication for Referral

Reason for Referral _____

Diagnosis(es)/Code _____

CPT Code _____

List Patient's Clinical Condition, Lab Data, or Other Diagnostic Data _____

_____

Requested Consultation or Service _____

Requested (Refer to) Provider Information

_____ _____ _____
Requested Provider/Facility Name | Phone | Fax

Authorization *(to be completed by Utilization Management)*

☐ Approved ☐ Deferred

Reason for Deferment _____

Fax authorization requests to Utilization Management at (888) 238-2337. Routine authorization requests are rendered within five (5) days; urgent requests in 72 hours. Please call (866) 644-5025 for authorization status.