AUTHORIZATION FORM

Request Date _____

This authorization is valid for 90 days, unless otherwise indicated. Only authorized services may be provided.

For urgent referrals, please contact the Referral Coordinator at (866) 871-2305.

Fax to (312) 491-9856 or submit electronically on the web portal at www.ccaillinois.com or via email at Referrals@ccaillinois.com.

ENROLLEE INFORMATION	TO BE COMPLETED BY PLAN
Enrollee name	Authorization Date
CCAI ID	Authorization Number
Effective Date	**RECEIVING PROVIDER INFORMATION**
PCP INFORMATION	Provider Name
PCP Name	In Network: ❒ Yes ❒ No
Address	Phone
City State Zip	**RECEIVING FACILITY**
Phone	In Network: ❒ Yes ❒ No
Fax	Phone

TREATMENT REQUESTED

❒CONSULT ❒SURGERY ❒TEST ❒OB ❒HH
❒THERAPY ❒LAB ❒DME ❒INPT ADMIT ❒LTSS/HCBS

ICD	Diagnosis Description
Services Procedure	
CPT(s)	Quantity
Begin Date	End Date

Additional comments or other relevant information:

Plan notes:

- ***Consultation Report*** *to be completed by the referred provider and returned to the Referral Coordinator and PCP as soon as possible.*
- *Please see* ***Prior Authorization List*** *for the services that require authorization prior to the date services are rendered.*
- ***Do not*** *hospitalize or refer the Enrollee to another provider without the approval of the referring physician and health plan.*

Important Note: This authorizes services for Enrollees with valid insurance with our plan. This referral does not authorize benefits for non-covered services. Approved referrals and payment are contingent upon eligibility on the date of service.