CHAMPION HEALTH PLAN

AUTHORIZATION SERVICE REQUEST FORM

Please Submit Consult Notes with this Form
Fax: (949) 850-2542 | email: um@championpayer.com

The use of this form is optional. You can call Champion Health Plan's Member Services Department at 1-800-885-8000 | TTY 711 to verbally request a service and/or a referral.

Date: _____

Request Type: ☐ Urgent (Expedited) ☐ Standard

1

Patient Name: _____ Phone #: _____

Address: _____ City: _____ State: _ Zip: _____

Patient ID #: _____ ☐ Male ☐ Female DOB: _____ Age: _____

Parent/Legal Guardian: _____ Phone #: _____

Referring to: _____ Specialty: _____

2

Nephrologist: _____ Phone #: _____ Fax #: _____

3

Service Requested: _____

_____

_____

For DME, Therapy, HHC Please Provide Duration & Frequency: _____

ATTACHMENTS:
☐ Lab
☐ X-Ray
☐ Other

4

PHYSICIAN RECOMMENDATION FOR INPATIENT STAY/OUTPATIENT SURGERY/PROCEDURES:

☐ INPATIENT ☐ OUTPATIENT SERVICES/TEST ☐ DIAGNOSTIC SERVICES/TEST

Facility: _____

Anesthesia ☐ YES ☐ NO Surgery ☐ YES ☐ NO

Admit Date: _____ Time: _____ Estimated Length of Stay: _____

Work Accident ☐ YES ☐ NO

Signature: _____ Date: _____

Print Name: _____

If you have questions, please contact Champion Health Plan Member Services at 1-800-885-8000 | TTY 711 Monday-Friday, 8 am - 8 pm or visit championhmo.com.

FOR PLAN USE ONLY

ICD-10:_____

CPT/HCPCS:

Dx:_____

CPT/HCPCS:

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