CHAMBERCARE

ChamberCare
Pre-Authorization Request Form

To expedite – Please submit your request online at www.ChamberCare.org.
Don't have an account? Contact your office administrator to get started.
Fax: 812-378-7054 Phone: 844-644-3004

Date and Time Submitted
_____
am/ pm ET/ CT

Section I — General Information

Review Type ☐ Non Urgent ☐ Urgent	Clinical reason for urgency
Request Type ☐ Initial Request	☐ Extension/Renewal/Amendment (Prev. Auth. #:)

Section II — Patient Information

Name	Patient Contact Phone	DOB	Sex ☐ Male ☐ Female ☐ Unknown
Member or Medicaid ID #	Group #		

Section III — Provider Information

Requesting Provider or Facility		*Service Provider or Facility*	
Name		Name	
NPI #	Group NPI#	NPI #	Group NPI#
Phone	Fax	Phone	Fax
Address		Address	
Tax ID		Tax ID	

Section IV — Services Requested (with CPT, CDT, or HCPCS Code) and Supporting Diagnoses (with ICD Code)

Planned Service or Procedure	*Code*	*Start Date*	*End Date*	*Diagnosis Description (ICD Version 10), if available*	*Code*

☐ Inpatient ☐ Outpatient ☐ Radiology ☐ Provider Office ☐ Observation ☐ Home ☐ Day Surgery ☐ Oncology ☐ Other (specify)

☐ Physical Therapy ☐ Occupational Therapy ☐ Speech Therapy ☐ Cardiac Rehab ☐ Mental Health/Substance Abuse

Number of sessions: Duration: Frequency: Other:

☐ Home Health – **MD signed Order Required** (Nursing Assessment attached? ☐ Yes ☐ No)

Number of visits requested: Duration: Frequency: Other:

☐ DME – **MD signed Order Required** ☐ Rental $_____ . ____ Per _____ ☐ Purchase $_____ . ____

Equipment/supplies (Include any HCPCS Codes): Duration:

☐ Medication – **MD signed Order Required** ☐ MD Supplying and Billing OR ☐ Retail

Duration of Use: Number of Units:

Section V — Extra Notes/Additional Codes

Section VI — Clinical Documentation – Please attach clinical documentation to support this request. If this request is for medication, please list other medications tried and failed when applicable.

Contact Name and Phone Number/Email regarding this request is _____