blue california
Promise Health Plan

Blue Shield of California Promise Health Plan
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CBAS SD Fax: (619) 219-3308

TREATMENT AUTHORIZATION REQUEST

for Community Based Adult Services (CBAS)

Member Name:	DOB:
Member ID#:	Member Phone Number:
CBAS Facility Name:	CBAS Facility ID/NPI:
CBAS Facility Address:	CBAS Facility Contact Person (Optional):
CBAS Phone Number:	CBAS Fax Number:
Service Requested: CBAS **Procedure Code:** S5102 = Day Care Services H2000 = IPC Evaluation	**Indicate Authorization Request Type:** (Initial / Continuation / Modification)

Dates of Service	Quantity per Month	Procedure Code/Comments

****Attach updated IPC <u>AND Participant Attendance Records</u> (for existing authorizations) with request.****

Requesting Provider (Print): Signature: Date:

THIS AUTHORIZATION DOES NOT GUARANTEE ELIGIBILITY.
CHECK ELIGIBILITY PRIOR TO RENDERING SERVICE.

UM Decision Status: ◯ APPROVED ◯ MODIFIED ◯ DENIED	
Authorization Number:	Date Approved
Reviewer's Name	Signature Date