Outpatient Prior Authorization Fax Request Form

Community Health Solutions of Louisiana

Complete the Form Below and Attach Clinical Information that Supports the Request for Services.
Fax to 1-877-448-8366.
If requesting therapies (i.e., ST/OT/PT), please give start date, length of therapy, and quantity of visits. If requesting private duty nursing, please provide number of hours per week.

Date: _____

Ordering Doctor Requesting Outpatient Service: _____

NPI/TIN #: _____

Phone: _____ **FAX:** _____

Outpatient Facility or Ancillary Provider Requesting: _____

NPI/TIN #: _____

Name of Person Submitting Request: _____

Phone: _____ **FAX:** _____

Contact for Follow-Up: _____

Phone: _____ **FAX:** _____

Patient Name: _____

Patient Date of Birth: _____ **Medicaid ID:** _____

Phone: _____ **Address:** _____

Diagnosis (ICD Code(s)/Description): _____

Procedure (CPT Code(s)/Description): _____

Start Date of Service: _____ **End Date of Service:** _____

For Therapies: Total Number of Visits Requested: _____

Frequency (i.e., per Week/Month): _____

Comments: _____