COMMUNITY SUPPORTS PRIOR APPROVAL FORM

FOR HOUSING DEPOSITS, HOME MODIFICATION, AND COMMUNITY TRANSITION SERVICES

SEND TO **CSPreApprovals@sfhp.org**

SAN FRANCISCO HEALTH PLAN™

Here for you

NOTE: ALL FIELDS MARKED WITH AN ASTERISK (*) ARE REQUIRED

TYPED ONLY - NO HANDWRITTEN FORMS

Select all that apply: ☐ New Request ☐ Modify Prior Request

Select applicable CS service: ☐ Housing Deposits ☐ Home Modifications ☐ Community Transitions Service (At least one valid CS service is required)

PATIENT	RENDERING PROVIDER
Name*:	Name*:
SFHP ID#*: Date of Birth*:	Telephone*:
Telephone:	**Contact Name:** Fax:
Address:	Address:

JUSTIFY THE GOODS/SERVICES AND DESCRIBE HOW THEY MEET MEMBER NEEDS*

COMMUNITY SUPPORTS SERVICE TYPES

☐ Housing Deposits ☐ Home Modifications ☐ Community Transitions Service (At least one valid CS service is required)

QTY OF ITEM	NAME OF ITEM	DESCRIPTION	VENDOR (Amazon, IKEA, etc.)	COST PER UNIT	TOTAL COST

Authorizations are based on medical necessity and covered services. Authorizations are contingent upon member's eligibility and benefits and are not a guarantee of payment. The provider is responsible for verifying member's eligibility on the date of service. Please verify eligibility using one of the following methods: 1. Web: **sfhp.org/providers** 2. Interactive Voice Response: **1(415) 547-7810** 3. SFHP Customer Services: **1(800) 288-5555**

Comments:

Signature*: Submission Date*:

Important: Please attach appropriate documentation to support your request.