Community-Based Adult Services (CBAS) Initiation and/or Prior Authorization Request

SAN FRANCISCO HEALTH PLAN™
Here for you

MEMBER INFORMATION

Date:	Date of Birth (DOB):
Last Name, First Name:	
CIN/Medi-Cal#:	SFHP ID#:
Primary Language: ☐ English ☐ Cantonese ☐ Mandarin ☐ Russian ☐ Spanish ☐ Tagalog ☐ Vietnamese ☐ Other (Write in):	
Interpreter Needed? ☐ YES ☐ NO	
Gender: ☐ Male ☐ Female ☐ Transgender ☐ Other:	
Member Address: City: State: Zip:	
Phone:	

REQUESTING CBAS PROVIDER / AGENCY INFORMATION

CBAS Center Name:	NPI#:
Contact Person:	
Phone:	Fax:
Address: City: State: Zip:	

CBAS REFERRAL INITIATION

ICD-10 (Required):

- Is this an urgent request? ☐ YES ☐ NO
- If yes, why:

Justification/Notes:

CHECK SERVICE REQUESTED

☐ Initial Evaluation ☐ Reassessment ☐ Change of Status ☐ ERS Transfer: Select One Discharge: Select One

LINE	CBAS SERVICES REQUESTED		# OF DAYS/WK	PROCEDURE CODE
1	FROM	THRU		Select One
2	FROM	THRU		Select One

CEDT ASSESSOR DISPOSITION

☐ Approved as Requested ☐ Denied ☐ Deferred ☐ Modified Number of Days/Weeks Approved:

Documentation Submitted: ☐ IPC – Original ☐ IPC – Updated ☐ CDA 4000	Comments:
By (CEDT Assessor):	Date: