

**HCHCP FAX FORM**

**Fax to: 1**- **866**- **889**- **6516 Date:**

|  |  |  |
| --- | --- | --- |
| **1. Member Subscriber Number (10 digit ID):** | **2. Member Last Name:** | **3. Member First Name:** |

**5. Sex: o M o F**

**4. Date of Birth:**

**6. Requesting Provider NPI Number:**

**7. Attending Provider NPI Number** (optional)**:**

**8. Servicing Provider NPI Number:**

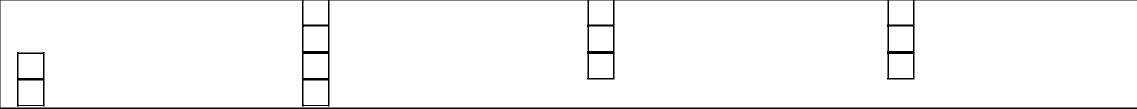
**9. PCP/Facility NPI** (Facility to be populated for OP Surgery/ PCP for all other request)**:**

1. **Treatment Setting**

**Imaging**

**Dental**

**Inpatient Rehab**



(Please check one)**:**

**Wound Care**

**Physician Office**

**Home Health**

**Inpatient Admission**

**Pain Management**

**Rehab Outpatient**

**Transportation**

**Outpatient Surgery**

**DME**

1. **Admission/Start Date:**

**0. Primary Diagnosis (DX) Code:**

**2. Primary Procedure CPT Codes:**

**1. Primary Diagnosis (DX) Description:**

**3. Primary Procedure CPT Code Description:**

1. **Number of Days Requested:**

**\*Please note**- **clinical information may be attached to form, this is not mandatory\***

1. **Presenting Signs and Symptoms/Treatment/History/Abnormal Findings/Reports:**

**1.Physician Office Fax Number:**

**2.Physician Office Telephone (Direct name and extension):**

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