Clinical Trial Prior Authorization Request Form

COMMUNITY HEALTH PLAN of Washington™ | COMMUNITY HEALTH NETWORK of Washington™

APPLE HEALTH (MEDICAID) MEDICARE ADVANTAGE CASCADE SELECT

For expedited processing for both Apple Health/Medicaid, Medicare Advantage Plans and CHNW-Cascade Select please submit Prior Authorization requests via the Care Management Portal at https://jiva.chpw.org/cms/ProviderPortal

Alternately, you can fax Prior Authorization requests to the appropriate number below:

For Apple Health/Medicaid:	For Medicare Advantage Plans:	For Cascade Select:
Fax: (206) 652-7078	**Fax: (206) 652-7065**	**Fax: (206) 652-7075**
Notification is required by next business day	Notification is required within 24 hours	Notification is required within 24 hours
Please call Customer Service to verify eligibility & benefits: **1-800-440-1561;** **Monday through Friday, 8 a.m.-5 p.m.**	Please call Customer Service to verify eligibility & benefits: **1-800-942-0247;** **7 days a week, 8 a.m. - 8 p.m.**	Please call Customer Service to verify eligibility & benefits: **1-866-907-1906;** **Monday through Friday, 8 a.m.-5 p.m.**

- Please refer to the Procedure Code Lookup Tool on the website **https://forms.chpw.org/pclt** for all the services that require prior authorization.
- **With your submitted form, please attach supporting clinical documentation.**
- Incomplete forms and requests without clinical information will delay processing
- A Prior Authorization is not a guarantee of payment; Payment is subject to member eligibility and benefits at the time of service.

ORDERING PROVIDER INFORMATION

First Name:	Last Name:	Contact Phone:	Contact Fax#:

Contact Person at this office: ☐ Ordering provider is PCP — PCP's Clinic Name: ☐ Ordering provider is Specialist — Specialty:

PATIENT INFORMATION

First Name:	Last Name:	MI:	Date of Birth:

Member ID: ☐ Patient Retro Enrolled with CHPW Retro Enrolled Date:

SERVICE PROVIDED BY

First Name:	Last Name:	Address:

☐ Participating ☐ Non-Participating	Tax ID: NPI:	Specialty:	Contact Phone #:	Contact Fax #:

Facility Name: Address:

☐ Participating ☐ Non-Participating	Tax ID: NPI:	Specialty	Contact Phone #:	Contact Fax #:

☐ Inpatient ☐ Outpatient Please indicate **CLINICAL** urgency of request ☐ Routine ☐ Urgent

Diagnosis: Primary: Code (_____) Description:_____ Date of Service:

Secondary: Code (_____) Description:_____

Services being requested:

CPT /HCPCS #1_____ Description:_____

CPT /HCPCS #2_____ Description:_____

CPT /HCPCS #3_____ Description:_____

☐ New request ☐ Extension Request*

#Visits:_____Duration: _____

*Last Date of service if an extension _____

Clinical Trial name and number:

Clinical Trial Phase that is conducted in relation to the prevention, detection, or treatment of cancer or other conditions.

☐ Phase I ☐ Phase II ☐ Phase III ☐ Phase IV

Is the member qualified to participate in an approved clinical trial according to trial protocol? ☐ Yes ☐ No

Is the attached Attestation form completed and included in this request? ☐ Yes ☐ No

Is the clinical trial federally approved or funded (which may include funding through in-kind contributions) by one or more of the following entities? ☐ Yes ☐ No

Select as applicable:

☐ The National Institute of Health (NIH)

☐ The Center for Disease Control and Prevention (CDC)

☐ Agency for Health Care Research and Quality (AHRQ)

☐ The Centers for Medicare & Medicaid Services (CMS)

☐ A cooperative group or center of any entities above or the Department of Defense or the Department of Veterans Affairs

☐ A qualified non-governmental research entity identified in the guidelines issued by the NIH for center support grants

☐ Other (specify)

_____

When applicable, choose one of the following:

☐ The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration (FDA).

☐ The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

MEDICAID ATTESTATION FORM ON THE APPROPRIATENESS OF THE QUALIFIED CLINICAL TRIAL

Participant

Participant Name: _____

Medicaid, Medicare or Cascade Select I.D.: _____

Qualified Clinical Trial

National Clinical Trial Number (from clinicaltrials.gov): _____

Principal Investigator Attestation

Principal Investigator Name: _____

☐ I hereby attest to the appropriateness of the qualified clinical trial in which the individual identified above is participating.

☐ The Principal Investigator is also the Health Care Provider and hereby attests to the appropriateness of the qualified clinical trial in which the individual identified above is participating.

Signature: _____ Date: _____
(*signature of principal investigator*) (*month, day, year*)

Health Care Provider Attestation

Health Care Provider Name: _____

☐ I hereby attest to the appropriateness of the qualified clinical trial in which the individual identified above is participating.

Signature: _____ Date: _____
(*signature of health care provider*) (*month, day, year*)

PRA Disclosure Statement - This information is being collected to assist the Centers for Medicare & Medicaid Services in implementing Section 210 of the Consolidated Appropriations Act of 2021 amending section 1905(a) of the Social Security Act (the Act), by adding a new mandatory benefit at section 1905(a)(30). Section 210 mandates coverage of routine patient services and costs furnished in connection with participation by Medicaid beneficiaries in qualifying clinical trials effective January 1, 2022. Section 210 also amended sections 1902(a)(10)(A) and 1937(b)(5) of the Act to make coverage of this new benefit mandatory under the state plan and any benchmark or benchmark equivalent coverage (also referred to as alternative benefit plans, or ABPs). Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. An agency may notconduct or sponsor, and a person is not required to respond to, a collection of information unlessit displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-0193. Public burden for all of the collection of information requirements under this control number is estimated to take about 56 hours per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 SecurityBoulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.