

CERTIFICATION REQUEST FORM



CHP CARE MANAGEMENT
Your Health Matters™



Fax #831-657-2669
Office #831-657-2668
200 Camino Aguajito, #302, Monterey, CA 93940

Request Date:		
Sender's Name:	Fax #	Office #
Patient's Name:	Date of Birth:	
Patient's Group Number:	177815 (CHOMP employees and dependents)	
Patient's Current Address:		
Patient's Current Home Phone #		
Service type (circle one):	OUTPATIENT	INPATIENT (Anticipated LOS _____)
Facility (procedure location):		
Physician Name:		
Procedure Date:	<i>(Please provide "tentative" date if procedure not scheduled as yet)</i>	
Diagnosis: <i>Describe fully here & place codes below.</i>		
ICD-9 Codes:		
Procedure: <i>* see note below</i>		
CPT Codes:		

***In order to process your request as quickly as possible, clinical information (chart notes, diagnostic studies etc.) *must* be included with this request. Thank you!**

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