

College Health IPA

Retro-Authorization Request

Patient Name	DOB
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Diagnosis	
I	IV
II	V
III	

Symptoms, including risk factors.

Medications and dosage – If none please indicate why medications not indicated.

Treatment Goal

Treatment Plan

Treatment Progress

Retro-authorization requested (Dates of Service and CPT Codes)

Additional Authorization requested (Number of Sessions, Frequency, and CPT Code)

Under the terms of your Provider Agreement or Single Case Agreement you are required to comply with the requirements of the member's benefit plan for requesting pre-authorization of services. Please provide an explanation for why pre-authorization of services was not requested:

Provider Name & License:	Date:
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Fax completed form to CHIPA at 877-803-3182