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:**	
4. Date of Birth:	**5. Sex:** ☐ **M** ☐ **F**		
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)**:**
10. Treatment Setting (Please check one)**:** ☐ **Inpatient Admission** ☐ **Outpatient Surgery**	☐ **Imaging** ☐ **Wound Care** ☐ **Pain Management** ☐ **DME**	☐ **Dental** ☐**Physician Office** ☐ **Rehab Outpatient**	☐ **Inpatient Rehab** ☐ **Home Health** ☐**Transportation**
11. Admission/Start Date:			
12. Primary Diagnosis (DX) Code:	**13. Primary Diagnosis (DX) Description:**		
14. Primary Procedure CPT Codes:	**15. Primary Procedure CPT Code Description:**		
16. Number of Days Requested:			
Please note- clinical information may be attached to form, this is not mandatory			
17. Presenting Signs and Symptoms/Treatment/History/Abnormal Findings/Reports:			

18. Physician Office Fax Number: _____

19. Physician Office Telephone (Direct name and extension): _____