Community Health Worker Supervising Provider Authorization Form for Additional Units

Important reminders for Medi-Cal Managed Care (Medi-Cal) members:

- Anthem Blue Cross (Anthem) requires an authorization for Community Health Worker (CHW) services beyond 12 units of services in a calendar year.
- For asthma prevention services, Anthem requires an authorization beyond eight units of services in a calendar year.
- This request form does not apply to CHW services provided in the emergency department.

Member information	
Member name:	**Date of birth:**
Medi-Cal Client Index Number (CIN):	**Residing county:**
CHW supervising provider information	
Name:	
Address:	
City:	**State:**
ZIP code:	**County:**
NPI:	**Tax ID:**
Contact name:	**Contact phone:**
Contact email:	**Contact fax:**
Request details	
ICD-10-CM code(s):	
Select CPT® code: ☐ 98960 ☐ 98961 ☐ 98962	**Number of units requested:**

Always include the following supporting documents when submitting the *Authorization Request Form*:

☐ Recommendation for frequency and duration of additional services

☐ Plan of care:

- The provider ordering the plan of care does not need to be the same provider who initially recommended CHW services or the supervising provider for CHW services.
- CHWs may participate in the development of the plan of care and may take a lead role in drafting the plan of care if done in collaboration with the member's care team and/or other providers.
- The plan of care may not exceed a period of one year.
- Quantity limits can be applied to goals detailed in the plan of care.
- **The attached plan of care must meet all of the following**:
  - ☐ It is written by one or more individual **licensed** providers, which may include the recommending provider and other licensed providers affiliated with the CHW supervising provider
  - ☐ Includes a list of other health care professionals providing treatment for the condition or barrier
  - ☐ Specifies the condition or barrier that the relevant service is being ordered for
  - ☐ Contains written objectives that specifically address the condition or barrier
  - ☐ Lists the specific services required for meeting the written objectives
  - ☐ Includes the frequency and duration of CHW services (not to exceed the provider's order) to be provided to meet the plan's objectives

Return this form with supporting documents via fax at 844-429-9626 or email: AnthemCHWReferral@anthem.com. Please allow five business days for processing.

https://providers.anthem.com/ca

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