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:** o **M** o **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)**:**	☐ **Imaging**	☐ **Dental**	☐ **Inpatient Rehab**
☐ **Inpatient Admission**	☐ **Wound Care**	☐ **Physician Office**	☐ **Home Health**
☐ **Outpatient Surgery**	☐ **Pain Management**	☐ **Rehab Outpatient**	☐ **Transportation**
	☐ **DME**		

11. Admission/Start Date:	
0. Primary Diagnosis (DX) Code:	**1. Primary Diagnosis (DX) Description:**
2. Primary Procedure CPT Codes:	**3. Primary Procedure CPT Code Description:**
4. Number of Days Requested:	

Please note- clinical information may be attached to form, this is not mandatory

5. Presenting Signs and Symptoms/Treatment/History/Abnormal Findings/Reports:

1.Physician Office Fax Number:

2.Physician Office Telephone (Direct name and extension):