Anthem BlueCross

Medi-Cal Managed Care

Request for Community Based Adult Services Fax Coversheet

Authorization request for reassessment should be faxed to 1-855-336-4041.

Date request submitted: _____

Request type (Check one.):
☐ New ☐ New urgent (nursing facility or hospital only)
☐ Renewal decrease in days ☐ Renewal increase in days ☐ Renewal same number of days

Number of days per week requested for next six months: _____

Total number of visits requested over six months: _____

Community Based Adult Services (CBAS) intake information:

Member information
Member name: _____ Date of birth: _____ Age: _____
Member State ID number: _____ Sex: ☐ Male ☐ Female
Anthem Blue Cross ID number (if known): _____
Preferred language: _____
Address: _____
City: _____ State: _____ ZIP code: _____
Phone: _____

Physician information
Requesting physician name: _____ License number: _____
Tax ID number: _____ NPI number: _____
Address: _____
City: _____ State: _____ ZIP code: _____
Phone: _____

CBAS provider Information
Start date for services: _____ Diagnosis description: _____
ICD-10 code(s): _____
Service request description: _____
CPT®/HCPCS code: _____
Name of CBAS facility: _____
CBAS tax ID/Medicare ID #: _____
Address: _____
City: _____ State: _____ ZIP code: _____
Phone: _____

https://mediproviders.anthem.com/ca

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List member's place of residence (home, board and care, independent care facility, etc.).:

Note if member lives home alone or with a caregiver (if caregiver, list name and contact information).:

If member has bladder incontinence, please note if stress, urge, functional or overflow, etc.:

Requests for CBAS services require specific clinical information for us to review requested services. Always include the relevant clinical information with the *CBAS Request* form. Please submit clinical information from your own files that would support the request. Thank you.