



Request for Community Based Adult Services Fax Coversheet

Authorization request for reassessment should be faxed to 1-855-336-4042.

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.