Community HEALTH OPTIONS®

Urine Drug Screen Prior Approval Form

Fax completed form to Medical Management to (877) 314-5693

Member Information (*Denotes Required Field)		
*Patient Name:	*☐ Male *☐ Female	*DOB:
*Health Insurance ID#:	Other Health Insurance (please specify):	
Address:	Phone:	

Provider Information	
***Requesting/Ordering Provider:**	***Servicing/Rendering Provider or Facility:**
*Name:	*Name:
*Address:	*Address:
*Tel:	*Tel:
*Fax:	*Fax:
*Contact Person:	*Specialty:
*Contact Tel:	*NPI:
*NPI	Please list additional provider information, if applicable, to include name, NPI & location.

Clinical Summary or clinical notes must be attached. Incomplete information may delay decision process.

Diagnosis Information (*Denotes Required Field)	
*ICD10 (List codes AND description):	
1.	3.
2.	4.

Planned Procedure Information (*Denotes Required Field)

Note: Community Health Options does not cover urine drug testing in any of the following circumstances:

- **Testing ordered by third parties, such as school, courts, or employers or requested by a provider for the sole purpose of meeting the requirements of a third party.**
- **Testing for residential monitoring.**
- **Routine urinalysis for confirmation of specimen integrity.**

☐ **UDS benefit limit (per rolling 12 months):**
- **20 Presumptive (qualitative)**
- **20 Definitive (quantitative)**

☐ **Out-of-network (OON) services**
For all OON Services, please advise Member to call Member Services at (855) 624-6463 to inquire about OON benefit coverage.

☐ **Urine Drug Screening (presumptive; qualitative)**

☐ **Urine Drug Screening (definitive; quantitative)**

CPT/HCPCS Code	Description	# of units or visits	CPT/HCPCS Code	Description	# of units or visits
1.			6.		
2.			7.		
3.			8.		
4.			9.		
5.			10.		

*Date(s) of service/ planned procedure/admission:

Start: End: