P.O. BOX 11045
ORANGE, CA 92856
Phone: (855) 227-1314
Email: cbasteam@caloptima.org

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REFERENCE NO:	**Status:** ☐ **Approved as Requested** ☐ **Denied** ☐ **Approved as Modified** ☐ **Deferred**

Benefit Inquiry for Community-Based Adult Services (CBAS)

☐ **Routine Request Fax Number:(714) 481-6423** ☐ **Expedited Request Fax Number: (714) 481-6422**

SECTION I

Patient Name: _____ ☐ **M** ☐ **F** **D.O.B.** _____ **Age:** _____
Last First

Mailing Address: _____ **City:** _____ **ZIP:** _____ **Phone No:** _____

CIN/Medi-Cal #: _____ **Preferred Language:** _____

Alternate Contact (Family Member/Caregiver): **Phone No:**

SECTION II

If CBAS Center Inquiry, NPI#:

☐ **CBAS** ☐ **PCP** ☐ **HN/PMG** ☐ **CalOptima** ☐ **CBO** ☐ **Facility (Acute/SNF)** ☐ **Health Risk Assessment (HRA)**

Requestor Name:

Telephone Number: **Email:**

Address:

Relationship to Patient:

Requestor Signature (PCP/CM):

SECTION III

Information Regarding Patient's Need for Services:

SECTION IV

Additional Comments:

DO NOT WRITE BELOW THIS LINE

For CalOptima Use Only:

Signature: **Date:** **Phone Number:**