

**CONTRA COSTA HEALTH PLAN
UTILIZATION MANAGEMENT UNIT**

DISCLOSURE OF CRITERIA OR GUIDELINES MEMBER REQUEST FORM

Date: _____ Requestor: _____

Address: _____

Phone: _____ Fax: _____

Email: _____

Referral / Prior Authorization Number: _____

Specific Criteria or Guideline Requested: _____

The materials provided to you are guidelines used by this plan to authorize, modify, or deny care for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under your contract.

Email: Member.Services@cchealth.org

Phone: Member Services (877) 661-6230 (OPTION 2)

Fax: (925) 313-6047

Mailing Address: 595 Center Ave. Ste. 100, Martinez CA 94553

For Contra Costa Health Plan only:

Date request: _____

Date Criteria/Guideline _____ Initials: _____

Publisher and Title of Criteria/Guideline sent: _____
