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For CalOptima Use Only
REFERENCE NO:

For CalOptima Use Only
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

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Signature: _____

Date: _____

Phone Number: _____