**Health Services Prior Authorization Request Form**

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| **A determination notice will be mailed and/or faxed to the requesting provider, facility, and patient. Service is typically faster through electronic submission. Please contact your Provider Service Representative for InTouch portal access information.** | | | | | | | | | | | | | | | | |
| * Incomplete requests will delay the standard prior authorization process. * PacificSource Community Solutions responds to standard prior authorization requests within 14 calendar days. * Please include pertinent chart notes to support this request. | | | | | | | | | | | | | | | | |
| **Requesting Provider Contact Information** | | | | | | | | | | | | | | | | |
| Contact person: | | | | | | | | | | | | | | Date: | | |
| Phone: | | | | | | | | | | | | | | Fax: | | |
| **Patient Information** | | | | | | | | | | | | | | | | |
| Patient Name: (First, M.I., Last) | | | | | | | | | | | | | | | | |
| DOB: | | | | | Member ID: | | | | | | | | | | | |
| OHP/Medicaid ID: | | | | | | | | | | | | | | | | |
| **Procedure Information** | | | | | | | | | | | | | | | | |
| |  |  |  | | --- | --- | --- | | CPT / HCPCS Procedure Code(s) | Units / Visits Requested | Diagnosis Code(s) | |  |  |  | |  |  |  | |  |  |  | |  |  |  | |  |  |  | | Refer to Comment section on Page 2 for additional codes. | | | | | | | | | | | | | | | | | | | |
| Requested Start Date: | | | | | | | | | Requested End Date: | | | | | | | |
| Assistant surgeon requested? |  | Yes | |  | | No | | | | | | | | | | |
| Are the services requested part of a clinical trial? |  | Yes | |  | | No | | | | | | | | | | |
| Are the services requested part of EPSDT services? |  | Yes | |  | | No | | | | | | | | | | |
| Is this a retrospective request\*? | |  | Yes | | |  | | No | | | | Date of service: | | |  |  |
| **Provider/Place of Service Information** | | | | | | | | | | | | | | | | |
| Ordering physician/provider: | | | | | | | | | | | | | | Tax ID: | | |
| Address where prior authorization form should be sent: | | | | | | | | | | | | | | | | |
| Phone: | | | | | | | | | | Fax: | | | | | | |
| Rendering / Service Provider / Vendor: | | | | | | | | | | | | | | Tax ID: | | |
| Does provider/vendor accept OHA rates? | | | | |  | | Yes | | | |  | | No | | | |
| Is this an Assertive Community Treatment (ACT) notification from an ACT provider? | | | | |  | | Yes | | | |  | | No | | | |
| Address where prior authorization form should be sent: | | | | | | | | | | | | | | | | |
| Phone: | | | | | | | | | | Fax: | | | | | | |
| Additional Notes/Comments: | | | | | | | | | | | | | | | | |

Fax Requests to:

* Behavioral Health Requests: 541-330-4910
* Physical Health Requests: 541-330-7339