

# Prior Authorization Request



We recommend submitting your request online at [Intouch.PacificSource.com](https://Intouch.PacificSource.com) for the most convenient service. Alternatively, you may use this form to submit a request via fax or mail.

- Please include pertinent chart notes to expedite this request.
- Incomplete information will delay the prior authorization process.

**Confidential fax:** 541-225-3625

**Questions?** Call us at **800-431-4135**, TTY: 711. We accept all relay calls.

## Timing

Standard

Urgent (NOTE: **Scheduling issues do not meet the definition of an urgent request**). I certify that this request is urgent and medically necessary to treat an injury, illness, or condition (not life-threatening) within 48 hours to avoid complications and unnecessary suffering or severe pain.

## Requesting provider contact information

Contact person \_\_\_\_\_ Office name \_\_\_\_\_ Date \_\_\_\_\_

Phone \_\_\_\_\_ Extension \_\_\_\_\_ Email \_\_\_\_\_ Fax \_\_\_\_\_

## Patient information

Last name \_\_\_\_\_ First name \_\_\_\_\_

DOB \_\_\_\_\_ Member number \_\_\_\_\_

## Procedure information

CPT/HCPCS procedure code(s)	Units/Visits requested	Diagnosis code(s)

Dates of service \_\_\_\_\_ To be scheduled

Outpatient Inpatient—do not use for ambulatory procedures. Refer to MCG Guidelines. We adhere to the IPO and ASC Exclusion List for Medicare only.

Existing authorization number \_\_\_\_\_

Dental under medical Request for additional units

Durable medical equipment Rental Purchase Cost \$ \_\_\_\_\_

Continued >

**Medicaid-specific:**

Are the services requested part of EPSDT services?    Yes    No

Are the services requested part of a clinical trial?    Yes    No

Is this an Assertive Community Treatment (ACT) notification from an ACT provider?    Yes    No

**Provider information**

Ordering provider or surgeon \_\_\_\_\_ NPI \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_ Tax ID \_\_\_\_\_

Does the ordering provider accept OHA rates?    Yes    No

Place of service, vendor, or facility \_\_\_\_\_ NPI \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_ Tax ID \_\_\_\_\_

Does the place of service accept OHA rates?    Yes    No

Rendering provider/vendor \_\_\_\_\_ NPI \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_ Tax ID \_\_\_\_\_

Does the rendering provider accept OHA rates?    Yes    No