PacificSource HEALTH PLANS

Behavioral Health Preauthorization Request Form

Please note:

- Please complete all fields on the form. Missing information will delay the preauthorization process.
- **Include current intake assessment and other applicable clinical documentation** and fax to **(541) 225-3667**.
- A facility license is **required** for all non-participating facilities.
- Please check specific preauthorization requirements for **self-funded plans.**
- We will mail or fax a determination notice to the requesting provider or facility and the patient.

If you have any questions, please feel free to contact the Behavioral Health Team at (541) 684-5582 or toll-free at (888) 977-9299 and enter extension 3980.

Please return to:
PacificSource
Attn: Health Services
Fax: (541) 225-3667

Patient

Last Name _____ First Name _____

Date of Birth _____/_____/_____ Member ID Number _____

Services

Type of Service _____

ICD 10 Diagnosis Code and Description _____

☐ Inpatient Admission Date _____ Estimated Length of Stay (days) _____

☐ Level 3.7 Withdrawal Management Admission Date _____ Estimated Length of Stay (days) _____

☐ Residential Admission Date _____ Estimated Length of Stay (days) _____

☐ Partial Hospitalization Program (PHP) Admission Date _____ Estimated Length of Stay (days) _____

Hours per Day _____ **x** Days per Week _____ **=** Total Hours _____

☐ Intensive Outpatient Program (IOP) Required After 36 Sessions: Start Date _____ End Date _____

Hours per Day _____ **x** Days per Week _____ **=** Total Hours _____

Retrospective Review? ☐ Yes ☐ No Dates of Service _____

Provider Contact Information

Contact Person:

Name _____ Date _____

Phone _____ Extension _____ Fax _____

Treating Provider:

Name _____ TIN _____ NPI _____

Phone _____ Extension _____ Fax _____

Address _____ City _____ State _____ Zip _____

Facility/place of Service:

Name _____ TIN _____ NPI _____

Phone _____ Extension _____ Fax _____

Address _____ City _____ State _____ Zip _____