

# Preauthorization Request Form



A determination notice will be mailed and/or faxed to the requesting provider, facility, and patient.

Network Exception request  
One Time Agreement request

- PacificSource responds to preauthorization requests within two (2) business days if received before 3:00 p.m.
- Requests received after 3:00 p.m. are processed the next work day.
- Incomplete information will delay the preauthorization process.
- Please include pertinent chart notes to expedite this request.
- Participating providers submit online through InTouch, at **PacificSource.com**

## 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 and description \_\_\_\_\_ CPT/HCPCS and description \_\_\_\_\_  
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CPT/HCPCS and description \_\_\_\_\_ CPT/HCPCS and description \_\_\_\_\_  
Diagnosis code and description \_\_\_\_\_  
Retrospective review? Yes No Dates of service \_\_\_\_\_ To be scheduled  
Inpatient Residential Estimated length of stay (number of days) \_\_\_\_\_  
Outpatient Office Home Durable medical equipment: Rental Purchase Cost \$ \_\_\_\_\_

## Provider Information

Ordering provider or surgeon \_\_\_\_\_ NPI \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone \_\_\_\_\_ Fax \_\_\_\_\_ Tax ID \_\_\_\_\_  
Place of service, vendor, or facility \_\_\_\_\_ NPI \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone \_\_\_\_\_ Fax \_\_\_\_\_ Tax ID \_\_\_\_\_

### Health Services Department

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