Facility Based Behavioral Health

Providence Health Plan | Yamhill Community Care

Inpatient, Residential, Partial Hospitalization and IOP Authorization Request

Chart Notes Required

Please fax to Behavioral Health: **503-574-8110** | Questions please call:503-488-2800 or 855-722-8205
NOTE: This form cannot be used to request ABA therapy, TMS or outpatient behavioral health services.

Member Information		
Last Name:	First Name:	
Insurance ID #:	DOB:	Phone:
Address:	Date of Admit	Date Span Requested:

Primary Care Physician (PCP):	
Requesting Provider:	TIN#:
Address:	NPI#:
Attending Provider:	TIN#:
Address:	NPI#:
Treating Facility:	TIN#:
Address:	NPI#:
Do you have an active DMAP #: ☐ Yes ☐ No ☐In Progress	All DMAP Administrative Rules, guidelines and applications to become an enrolled DMAP provider can be found at www.oregon.gov/OHA/healthplan.

Requested Level of Care/ASAM Level:

OUTPATIENT		**RESIDENTIAL**		**INPATIENT**	
☐ SUD – Level 2.1 (IOP) ☐ SUD – Level 2.5 (PHP)	☐ MH – IOP ☐ MH – PHP ☐ MH – Day Treatment	☐ SUD – Level 3.1 ☐ SUD – Level 3.3 ☐ SUD – Level 3.5	☐ MH RTC	☐ Subacute Detox – Level 3.7 ☐ IP Detox – Level 3.7	☐ IP MH ☐ MH Subacute

Day Treatment, IOP & Partial Hospitalization: # of Units being requested ___________ # of Days per Week being requested ___________

ICD-10 Code(s):	Revenue/CPT Code(s):

Expedite- defined as member's life, health or ability to regain maximum function is in serious jeopardy if determination is not made in the standard timeframe. **Request must include supporting documentation to substantiate an expedited review.**

Explanation Required:

Non-Contracted Facilities will need to request an Out of Network Exception. In the event a facility is unwilling to accept DMAP rates additional documentation supporting the enhanced rate will need to be provided. Please indicate your willingness to accept DMAP rates. ☐ Yes ☐ No

In-Network Benefits: **Request must include supporting documentation to substantiate why services cannot be provided by an in-network provider/facility. Please also submit facility's state license to provide level of care/service requested.**

Explanation Required:

REQUIRED **Utilization Review Contact Information**:		
Name:	Phone #:	Fax#:

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