

Facility Based Behavioral Health

Inpatient, Residential, Partial Hospitalization, and IOP

Prior Authorization Request

****Chart Notes Required****

Please fax to 503.850.9398 | Questions call 971.345.5930 or 833.257.2189

Expedited Request, Out of Network Benefits, or Out of Network Providers must complete the required sections

Member Information

| | |
|-----------------|-------------|
| Last Name: | First Name: |
| Insurance ID #: | DOB: |
| Address: | |

REQUIRED Contact Information

| | | |
|-------|--------|------|
| Name: | Phone: | Fax: |
|-------|--------|------|

Primary Care Physician (PCP):

Requesting Provider:

TIN#:

Address:

NPI#:

Servicing Provider:

TIN#:

Address:

NPI#:

Servicing Facility:

TIN#:

Address:

NPI#:

Do you have an active DMAP #: ☐ Yes ☐ No ☐ In Progress

Note: All DMAP administrative rules, guidelines, and applications to enroll can be found at www.oregon.gov/OHA/healthplan.

Requested Level of Care/ASAM Level:

| OUTPATIENT | RESIDENTIAL | INPATIENT |
|--|--|---|
| <input type="checkbox"/> SUD – Level 2.1 (IOP) | <input type="checkbox"/> SUD – Level 3.1 | <input type="checkbox"/> Subacute Detox – Level 3.7 |
| <input type="checkbox"/> SUD – Level 2.5 (PHP) | <input type="checkbox"/> SUD – Level 3.3 | <input type="checkbox"/> IP Detox – Level 3.7 |
| <input type="checkbox"/> MH - IOP | <input type="checkbox"/> SUD – Level 3.5 | <input type="checkbox"/> IP MH |
| <input type="checkbox"/> MH - PHP | <input type="checkbox"/> MH RTC | <input type="checkbox"/> MH Subacute |
| <input type="checkbox"/> MH – Day Treatment | | Date Span: _____ |

Day Treatment, IOP, & Partial Hospitalization:

of Units requested _____ # of Days per Week requested _____ Date Span: _____

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

Out of Network Facilities: Non contracted Facilities will need to request an Out of Network Exception. In 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 **Request must include supporting documentation to substantiate why services cannot be provided by an in-network provider/facility.**

☐ New Patient or ☐ Established Patient | Date Last Seen:

Explanation Required (Continued on Next Page):

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 time frame. **Request must include supporting documentation to substantiate an expedited review.**
Explanation Required:

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