# Health Related Social Needs (HRSN) Prior Authorization Request - Nutrition

****MTM Assessment and Chart Notes Required****

Please fax to 503.850.9398 I Questions call 855-722-8205

**Expedited Request must complete the required section**

| **Member Information** | |
|---|---|
| Last Name: | First Name: |
| Insurance ID #: | DOB: |
| Address: | County: ☐ Polk ☐Washington ☐Yamhill |
| Phone: | Email: |
| Preferred Language (Optional): | Pronouns (Optional): |

| ****Required** Requesting Provider Information** | | |
|---|---|---|
| Requesting Provider/Organization/Member: | Email: | |
| Address: | Phone: | Fax: |
| **Primary Care Physician (PCP):** | TIN#: | |
| **PCP Phone Number:** | NPI#: | |

**Eligibility Criteria** Member must meet **ALL** the following requirements. **MTM Assessment and Chart Notes Required.**
*If member does not meet HRSN eligibility, consider applying for HRS flex funds:*
https://yamhillcco.org/wp-content/uploads/YCCO-Flex-Funds-Request-1.pdf

☐ Be enrolled in the OHP under category CCOA or CCOB AND

☐ U.S. Household Food Security Survey Module:
https://www.ers.usda.gov/sites/default/files/_laserfiche/DataFiles/50764/short2024.pdf
Six-Item Short Form Score _____. Must qualify at low or very low food security. AND

☐ Meet AT LEAST ONE of the Nutrition Specific Clinical Risk Factors

- ☐ Complex Behavioral Health needs
- ☐ Developmental Disability Need
- ☐ Complex Physical Health Need
- ☐ Need for Assistance with ADLs or eligible for LTSS
- ☐ Interpersonal violence experience
- ☐ Adult 65 years of age or older
- ☐ Child less than 21 years of age
- ☐ Repeated ED use and crisis encounters
- ☐ Pregnant/Postpartum
- ☐ Young Adult with Special health care needs

**Type of Needs:** (check appropriate boxes)

| | |
|---|---|
| ☐ **Medically Tailored Meals (MTM)**<br>**(Up to 6 Months)**<br>MTM Assessment completion date _____<br>☐ MTM Assessment attached*<br>☐ Nutritional Care Plan completed and attached*<br>☐ Initial request ☐Renewal<br><br>*Required documentation must be attached or PA will be returned | ☐ **Nutrition Education**<br>☐ Member not eligible to receive Medical Nutrition Therapy (MNT) through OHP |

**Member Attestations** (must be completed in full)

☐ Member has attested they are not receiving duplicative services through other programs / the service is not currently meeting their needs

Member has consented to: ☐ Receive approved HRSN Services

☐ Be contacted by phone and text by YCCO staff

☐ Be contacted by phone by the service vendor for delivery and hook up

☐ Member agrees to be contacted and/or managed by Care Management (Optional)

☐ Agrees to the use of information technology methods of personal data sharing

| **ICD-10 Code(s):** | **CPT Code(s):** |
|---|---|
| | |

**Expedited-** 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:

**Additional Comments (Optional):**

**Additional Info:**

| Code | Modifiers | Requested Item/ Service: |
|---|---|---|
| | | |
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