

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

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

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

**Expedited Request must complete the required section**

### Member Information

Last Name:	First Name:
Insurance ID #:	DOB:
Address:	County: <input type="checkbox"/> Polk <input type="checkbox"/> Washington <input type="checkbox"/> Yamhill
Phone:	Email:
Preferred Language (Optional):	Pronouns (Optional):

### \*\*Required\*\* Requesting Provider Information

Requesting Provider/Organization/Member:	Email:	
Address:	Phone:	Fax:
<b>Primary Care Physician (PCP):</b>	TIN#:	
<b>PCP Phone Number:</b>	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
 

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

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

<input type="checkbox"/> <b>Medically Tailored Meals (MTM) (Up to 6 Months)</b> MTM Assessment completion date _____ <input type="checkbox"/> MTM Assessment attached* <input type="checkbox"/> Nutritional Care Plan completed and attached* <input type="checkbox"/> Initial request <input type="checkbox"/> Renewal	<input type="checkbox"/> <b>Nutrition Education</b> <input type="checkbox"/> Member not eligible to receive Medical Nutrition Therapy (MNT) through OHP
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**\*Required documentation must be attached or PA will be returned**

**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)

<b>ICD-10 Code(s):</b>	<b>CPT Code(s):</b>
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**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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