

## **Prior Authorization Request**

## \*\*Chart Notes Required\*\* Please fax to 503.850.9398 | Questions call YCCO Customer Service 855.722.8205

For High Tech Imaging	eviCore I Phone: 800 For Registration: https://www.https					
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#:		
Do you have an active DMAP #: ☐ Yes ☐ No ☐ In Progress  Note: All DMAP administrative rules, guidelines, and applications to become an enrolled DMAP provider can be found at <a href="https://www.oregon.gov/OHA/healthplan">www.oregon.gov/OHA/healthplan</a> .						
Servicing Facility:				TIN#:		
Address:				NPI#:		
Do you have an active DMAP #: ☐ Yes ☐ No ☐ In Progress  Note: All DMAP administrative rules, guidelines, and applications to become an enrolled DMAP provider can be found at <a href="https://www.oregon.gov/OHA/healthplan">www.oregon.gov/OHA/healthplan</a> .						
Type of Care:						
☐ Elective Inpation	ent Admit   □ Elective	Outpatient Surg	ery   🗆 Office Su	rgery   🗆 Outpatient Diagn	ostics   □ ASC	
ICD-10 Code(s):		CPT Code(s):		Requested Item/Ser	vice:	
Requested Service	es:					
□Office Visits,#of visits:  □ Surgery   □ Diagnostic   □ Facility Auth Only   □ DME   □Other						
Date of Service:			Date Span F	Date Span Requested:		
In-Network Benefits: ☐ New Patient or ☐ Established Patient   Date Last Seen:						

Comments:
Out of Network Benefits/Provider: Request must include supporting documentation to substantiate why services cannot be provided by an in-network provider/facility.
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 I Date Last Seen: Explanation Required:
<b>Expedite-</b> 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. <b>Request must include supporting documentation to substantiate an expedited review.</b> Explanation Required:

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12/12/2023