# 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 \| Phone: 800.918.8924\| https://www.evicore.com/ \|<br>For Registration: https://www.evicore.com/resources/healthplan/yamhill |

**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 www.oregon.gov/OHA/healthplan.

| | |
|---|---|
| **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 www.oregon.gov/OHA/healthplan.

**Type of Care:**

☐ Elective Inpatient Admit | ☐ Elective Outpatient Surgery | ☐ Office Surgery | ☐ Outpatient Diagnostics | ☐ ASC

| ICD-10 Code(s): | CPT Code(s): | Requested Item/Service: |
|---|---|---|
| | | |

**Requested Services:**

☐Office Visits,#of visits:____ | ☐ Surgery | ☐ Diagnostic | ☐ Facility Auth Only | ☐ DME | ☐Other _____

| | |
|---|---|
| **Date of Service:** | **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:

**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: