

# Prior Authorization Request

**\*\*Chart Notes Required\*\***

Please fax to 503.850.9398 | Questions call 971.345.5930 or 833.257.2189

For High Tech Imaging	eviCore   Phone: 800.918.8924   <a href="https://www.evicore.com/">https://www.evicore.com/</a>   For Registration: <a href="https://www.evicore.com/resources/healthplan/yamhill">https://www.evicore.com/resources/healthplan/yamhill</a>	
<b>Expedited Request, Out of Network Benefits, or Out of Network Providers must complete the required sections</b>		
<b>Member Information</b>		
Last Name:	First Name:	
Insurance ID #:	DOB:	
Address:		
<b>**REQUIRED** Contact Information</b>		
Name:	Phone:	Fax:
<b>Primary Care Physician (PCP):</b>		
Requesting Provider:		TIN#:
Address:		NPI#:
Servicing Provider:		TIN#:
Address:		NPI#:
<b>Do you have an active DMAP #:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress Note: All DMAP administrative rules, guidelines, and applications to become an enrolled DMAP provider can be found at <a href="http://www.oregon.gov/OHA/healthplan">www.oregon.gov/OHA/healthplan</a> .		
Servicing Facility:		TIN#:
Address:		NPI#:
<b>Do you have an active DMAP #:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress Note: All DMAP administrative rules, guidelines, and applications to become an enrolled DMAP provider can be found at <a href="http://www.oregon.gov/OHA/healthplan">www.oregon.gov/OHA/healthplan</a> .		
<b>Type of Care:</b>		
<input type="checkbox"/> Elective Inpatient Admit   <input type="checkbox"/> Elective Outpatient Surgery   <input type="checkbox"/> Office Surgery   <input type="checkbox"/> Outpatient Diagnostics   <input type="checkbox"/> ASC		
ICD-10 Code(s):	CPT Code(s):	Requested Item/Service:
<b>Requested Services:</b>		
<input type="checkbox"/> Office Visits, # of visits: ____   <input type="checkbox"/> Surgery   <input type="checkbox"/> Diagnostic   <input type="checkbox"/> Facility Auth Only   <input type="checkbox"/> DME   <input type="checkbox"/> Other _____		
<b>Date of Service:</b>		<b>Date Span Requested:</b>
<b>In-Network Benefits:</b> <input type="checkbox"/> New Patient or <input type="checkbox"/> 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. ☐ New Patient or ☐ Established Patient | 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:

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12/12/2023