TMS Prior Authorization Request

Chart Notes Required

Please fax to 503.850.9398 | Questions call 971.345.5930 or 833.257.2189

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 enroll 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 enroll can be found at www.oregon.gov/OHA/healthplan.

ICD-10 Code(s):	CPT Code(s)and Units per CPT Code being requested:
Initial Date of Service: **Date Span Requested:**	**Frequency of service requested** (i.e. one session per week):

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 | Date Last Seen:
Explanation Required (Continued on Next Page):

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: