

## TMS Prior Authorization Request

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

Please fax to 503.850.9398 | Questions call YCCO Customer Service 855.722.8205

**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:
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**Primary Care Physician (PCP):**

Requesting Provider:	TIN#:
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Address:	NPI#:
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Servicing Provider:	TIN#:
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Address:	NPI#:
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**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](http://www.oregon.gov/OHA/healthplan).

Servicing Facility:	TIN#:
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Address:	NPI#:
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**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](http://www.oregon.gov/OHA/healthplan).

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

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