

TOC

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/ 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 #: <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 www.oregon.gov/OHA/healthplan .		
Servicing Facility:		TIN#:
Address:		NPI#:
Do you have an active DMAP #: <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 www.oregon.gov/OHA/healthplan .		
Type of Care:		
<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:
Requested Services:		
<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 _____		
In-Network Benefits: <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.

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:

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