

**HEALTH SERVICES
PREAUTHORIZATION
REQUEST FORM**



**Please fax completed
form with chart notes
to: 541.225.3625**

A determination notice will be mailed and/or faxed to the requesting provider, facility, and patient.

- PacificSource responds to preauthorization requests within two (2) working days.
- Requests received after 3:00 p.m. are processed the next work day.
- **Incomplete information will delay the preauthorization process.**
- Please include pertinent chart notes to expedite this request.

REQUESTING PROVIDER CONTACT INFORMATION

Date: _____ Contact person: _____
Phone: _____ Extension: _____ Fax: _____

PATIENT INFORMATION

Last name: _____ First name: _____
DOB: _____ Member number: _____

PROCEDURE INFORMATION

CPT / HCPCS code and description: _____
CPT / HCPCS code and description: _____
CPT / HCPCS code and description: _____
Notes: _____
ICD-9 / DSM-IV code and description: _____
Retrospective review? Yes No Dates of service: _____ To be scheduled
 Inpatient Residential Estimated length of stay (number of days): _____
 Outpatient Office Home Durable medical equipment: Rental Purchase Cost \$ _____

PROVIDER INFORMATION

Ordering provider or surgeon: _____
Address: _____
City/State/Zip: _____ Tax ID: _____
Phone: _____ Fax: _____
Place of service, vendor, or facility: _____
Address: _____
City/State/Zip: _____ Tax ID: _____
Phone: _____ Fax: _____

Health Services Department
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