**Health Services Prior Authorization Request Form**

|  |
| --- |
| **A determination notice will be mailed and/or faxed to the requesting provider, facility, and patient. Service is typically faster through electronic submission. Please contact your Provider Service Representative for InTouch portal access information.**  |
| * Incomplete requests will delay the standard prior authorization process.
* PacificSource Community Solutions responds to standard prior authorization requests within 14 calendar days.
* Please include pertinent chart notes to support this request.
 |
| **Requesting Provider Contact Information** |
| Contact person: | Date: |
| Phone:  | Fax: |
| **Patient Information** |
| Patient Name: (First, M.I., Last) |
| DOB: | Member ID: |
| OHP/Medicaid ID: |
| **Procedure Information** |
|

|  |  |  |
| --- | --- | --- |
| CPT / HCPCS Procedure Code(s) | Units / Visits Requested | Diagnosis Code(s) |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
| Refer to Comment section on Page 2 for additional codes. |

 |
| Requested Start Date: | Requested End Date: |
| Assistant surgeon requested? |[ ]  Yes |[ ]  No |
| Are the services requested part of a clinical trial? |[ ]  Yes |[ ]  No |
| Are the services requested part of EPSDT services? |[ ]  Yes |[ ]  No |
| Is this a retrospective request\*? |[ ]  Yes |[ ]  No | Date of service: |  |  |
| **Provider/Place of Service Information** |
| Ordering physician/provider: | Tax ID: |
| Address where prior authorization form should be sent: |
| Phone: | Fax: |
| Rendering / Service Provider / Vendor:  | Tax ID: |
| Does provider/vendor accept OHA rates? |[ ]  Yes |[ ]  No |
| Is this an Assertive Community Treatment (ACT) notification from an ACT provider? |[ ]  Yes |[ ]  No |
| Address where prior authorization form should be sent: |
| Phone: | Fax: |
| Additional Notes/Comments: |

Fax Requests to:

* Behavioral Health Requests: 541-330-4910
* Physical Health Requests: 541-330-7339