

## Behavioral Health Preauthorization Request Form for ABA Services

## Please note:

- Requests received after 3:00 p.m. will be processed the next business day.
- Complete all fields on the form. Missing information will delay the preauthorization process.
- You can expect to receive a response within two business days.
- We will mail or fax a determination notice to the requesting provider or facility and the patient.

If you have any questions, please feel free to contact the Health Services Team at **(541) 684-5584** or toll-free at **(888) 691-8209**.

Participating providers submit online through InTouch.
Go to PacificSource.com/aboutproviderintouch for information.

| Patient           |                      |       |  |                       |       |  |
|-------------------|----------------------|-------|--|-----------------------|-------|--|
| Last name         |                      |       | First name   |                       |       |  |
| Date of birth/    |                      |       | Member ID number   |                       |       |  |
| Services          |                      |       |  |                       |       |  |
| •                 | code and description |       | is is required with sul                                  | omission of this form |       |  |
| ·                 |                      |       | Note: Request for maximum of <b>six-month</b> timeframe. |                       |       |  |
| •                 |                      |       | al units for requested                                   |                       |       |  |
| CPT Code          | Frequency            | Units | CPT Code   | Frequency             | Units |  |
| CPT Code          | Frequency            | Units | CPT Code   | Frequency             | Units |  |
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| CPT Code          | Frequency            | Units | CPT Code   | Frequency             | Units |  |
| CPT Code          | Frequency            | Units | CPT Code   | Frequency             | Units |  |
| Provider Conta    | ct Information       |       |  |                       |       |  |
| Contact Person    |                      |       |  |                       |       |  |
| Name              |                      |       | Date   |                       |       |  |
| Phone             |                      |       | Fax  |                       |       |  |
| Treating Provide  | er:                  |       |  |                       |       |  |
| Name              |                      |       | Phone  | Fax                   | Fax   |  |
| Address           |                      |       | City   | State                 | Zip   |  |
| TIN               |                      |       | NPI  |                       |       |  |
| Facility/Place of | f Service:           |       |  |                       |       |  |
| Name              |                      |       | Phone  | Fax                   | . Fax |  |
| Address           |                      |       | City   | State                 | Zip   |  |
| TIN               |                      |       | NPI  |                       |       |  |

## Please return to: