Advanced Health
289 LaClair St, Coos Bay, OR 97420
Voice: 541-269-7400 • 800-264-0014
Fax: 541-269-7147
TTY: 711 or 800-735-1232

Physician Authorization Request

☐ **STANDARD REQUEST** ☐ **EXPEDITED REQUEST - 72 hours (member's health is at immediate risk i.e. loss of life, limb, or eyesight imminent)** ***(Fill out Justification below:)***

****Justification within submitted documentation is required for Expedited processing. If your PA request does not meet Expedited criteria, it will receive Standard processing. Expedited requests are appropriate if Standard Time Frame could seriously jeopardize a Member's life or health, or their ability to attain or maintain or regain maximum function.**
JUSTIFICATION:

• Fax Completed Form <u>and chart notes</u> to 541-269-7147 *PLEASE NOTE: INCOMPLETE FORMS WILL NOT BE PROCESSED*

Check box if member has Special Healthcare Needs (SHCN) ☐

Member Name: ________________________________ Medicaid ID #: ____________________ DOB: ____/____/____

Requesting Provider: ____________________________ PCP ☐ Specialist ☐ Other ☐

Requesting Provider NPI#: ___________________________

Provider's Phone Number: ________________________ Provider's Fax Number: ______________________________

PRIMARY ICD-10 Code: ___________________________ Other Related ICD-10 Codes: _____________, _____________

Is this a retro-active request: ☐ Yes ☐ No If "Yes", enter the date of service: ____/____/____

****You must attach chart notes/operative report from that date.**

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<u>REFERRALS</u>:

Specialist Name: ____ Number of visits requested: _________________________

Specialist Address: ____

Specialist Phone Number: __________________________________ Specialist Fax Number: ______________________________

Specialist NPI#: ____________________________________ Name of Facility: ____

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<u>SURGERY/THERAPEUTIC PROCEDURE</u>: ***Sleep Study requests require an overnight oximetry report***
For Behavioral Health referrals please use the Behavioral Health Authorization Form, IIBHT (Intensive In-Home Behavioral Health Treatment) Form, or the Gender Dysphoria Form for those types of requests
Members must be smoke-free for 4 weeks prior to most non-emergent surgeries. Date Member stopped smoking: ____/____/____
(Refer to Ancillary Guideline A4 on the Prioritized List for details and exceptions)
Submit results from one of the following: ☐ Urine Cotinine ☐ Anabasine or anatabine ☐ Exhaled Carbon Monoxide

CPT/HCPCS Code(s) for procedure/service: ____________, ____________, ____________, ____________, ___________

Service / Procedure Location: ☐ Provider Office ☐ Ambulatory Surgery ☐ Outpatient Hospital ☐ Inpatient Hospital

Facility Name: ____

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Comments:

Person Completing Form: ____

Contact Person:____ Phone:_______________________ Fax:______________________

Date: ____/____/____

<u>Disclaimer</u>: Prior Authorization does not guarantee payment. Criteria is based on member eligibility on date of service, contract terms, and compliance with OAR rules, regulations and policies of CMS and Advanced Health.
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