

Prior Authorization Request

****Chart Notes Required****



Please fax this request to: 503-574-6464 or 800-989-7479

Please call our PA department if you have any questions at: 503-574-6400 or 800-638-0449

Member Information	
Last Name:	First Name:
ID #:	DOB:
Address:	
Provider Information	
Primary Care Physician (PCP):	
Requesting Provider:	TIN#:
Address:	NPI#:
Servicing Provider:	TIN#:
Address:	NPI#:
Servicing Facility:	TIN#:
Address:	NPI#:
Request Information	
ICD-10 Code(s):	
CPT Code(s):	
Requested Services: <input type="checkbox"/> Office Visits, # of visits: _____ <input type="checkbox"/> Surgery <input type="checkbox"/> Diagnostic <input type="checkbox"/> Facility Auth Only	Type of Service: <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient Surgery <input type="checkbox"/> Office Surgery <input type="checkbox"/> Outpatient Diagnostics <input type="checkbox"/> ASC
DOS:	Date Span Requested:
Comments:	
REQUIRED Contact Information:	
Name:	Phone #:
Fax #:	Total # of pages faxed, including cover page:
<input type="checkbox"/> In-Network Benefits being requested	<input type="checkbox"/> PLEASE EXPEDITE! The provider believes that waiting for a decision under the standard time frame could place the enrollee's life, health or ability to regain maximum function in serious jeopardy (CMS definition)