UMPQUA HEALTH ALLIANCE

A Coordinated Care Organization

PRIOR AUTHORIZATION FORM

Medical • SUD • Behavioral Health

Phone: (541)672-1685 Fax: (541) 677-5881

****SUPPORTING DOCUMENTATION IS REQUIRED TO BE SUBMITTED WITH ALL REQUESTS****

Medical & DME	Substance Use Disorder (SUD)	Behavioral Health
☐ **Skilled Nursing Facility** – 2 business days	☐ **Detoxification** – 2 business days	☐ **Inpatient or Residential** – 72 hours
☐ **Standard** - 14 days	☐ **Residential Treatment** – 2 business days	☐ **Standard** - 14 days
☐ **Expedite** - 72 hours (member's health is at immediate risk i.e. loss of life, limb, or eyesight imminent). Reason:	☐ **Medical Assisted Treatment (MAT)** – 2 business days	☐ **Expedite** - 72 hours (member's health is at immediate risk i.e. loss of life, limb, or eyesight imminent). Reason:
☐ **Retro Authorization**	☐ **Other**: _____	☐ **Retro Authorization**

Fields listed below in *RED are required fields. Failure to provide the required information may cause a delay in authorizations request to be cancelled/returned.

Member Information

First name:	Last name:	DOB:	ID:

Submitter Information

Name:	Clinic/Office:	Phone:	Fax:

Referring Provider Information

Name:		Phone:	Fax:
NPI:		Credentials:	
Address:		☐ MD ☐ DO ☐ PhD ☐ CADC ☐ LMFT/I ☐ LCSW/I ☐ LPC/I ☐ PSY ☐ PMHNP ☐ Other	

Delivering Provider Information

Name:		Phone:	Fax:
NPI:		Credentials: ☐ MD ☐ DO ☐ PhD ☐ CADC ☐ LMFT/I ☐ LCSW/I ☐ LPC/I ☐ PSY ☐ PMHNP ☐ Other	
Address:			

Procedure/Service Facility Information

Name:		NPI:	Fax:
Network Status ☐ In-network ☐ Out-of-network (OON) Requires document for justification to be seen OON.	**Place of Service** ☐ Outpatient/ in office ☐ Facility (Surgery Center) ☐ Residential ☐ Inpatient (Hospital)	**Financial Arrangement** ☐ Single Case Agreement (IP & Residential only) ☐ Specialty Financial Arrangement (DME only) ☐ Accept DMAP rates	**Residential & Inpatient** Admit Date: Discharge Date:

Diagnosis Code(s)

Primary:	Secondary:	☐ Initial Assessment

Procedure Code(s)

CPT/HCPC	Name/Description	Dose/QTY	Total	Start Date	End Date

☐ 2nd page attached of additional codes
☐ Chart notes attached
☐ Psychological Evaluation Form attached (if applicable)

Other important info:

PAYMENT FOR ALL SERVICES IS SUBJECT TO CONFIRMATION that the beneficiary is eligible to receive the services as a covered benefit, the applicability of other sources for payment, UHA's policies and procedures, the terms of its contract with the state of Oregon, and all applicable laws, each as in effect or determined at the time each service is performed. Umpqua Health Alliance operates a Medicaid plan under the Oregon Health Plan. If you are a nonparticipating provider, payment is made at the rate set out in the relevant Oregon Administrative Rule. Generally, those rules can be found at OAR Chapter 410.