

A Coordinated Care Organization Phone: (541) 672-1685 Fax: (541) 677-5881

PRIOR AUTHORIZATION FORM Medical Services & DME

| STANDA | IRD/ROUTINE 14 days | | | | | | | | | |
|-------------------------|--|--------------------------|--------------------|----------------|-----------------|--------------------|----------------|------------|---|--|
| submitting member or | hours (member's health is at in this form, I certify that apply the member's ability to rega mportant Information area be | ing the 72 hour stan | ndard review | time may | seriously | jeopardize t | he life or hea | Ith of the | l | |
| RETRO (| Service has already been deliv | vered/completed) DA | TE OF SER\ | ICE | | | | | | |
| | | | | | | | | | | |
| | **SUPPORTING DOCUITION d below in *RED are required | l fields. Failure to pr | | | | | | orizations | | |
| and/or auth | norizations to be cancelled/re | turned. | | | | | | | | |
| *Date: | Date: *Person completing form: | | | | *Phone: | | | | | |
| Provider/Clin | ic Name: | | | | | Fax: | | | _ | |
| | | Membe | er Informa | tion | | | | | | |
| *Name: | | *ID #: | | | *[| DOB: | | | | |
| | | Requesting P | rovider In | ormatio | n | | | | | |
| *Name: | | MD | DO I | NP | NP PA | A | | | | |
| *Address: | | | | | | | | | | |
| *NPI #: | *Phone | : | t d | Fax: | | | | | | |
| | | Delivering Pr | ovider Inf | ormatio | n | | | | | |
| *Name: | | *NPI #: | | | *P | hone: | | | | |
| *Address: | | | *Fax: | | | | | | | |
| | | Diagnos | is Informa | tion | | | | | | |
| | Diagnosis Code(s): | | | | | | | | | |
| *Primary: | Supporting: | | | | | | | | | |
| | | Procedure/Servi | ice/Facility | Informa | ation | | | | | |
| СРТ/НСРС | Name/Description | Strength (if applicable) | Do | se (if applica | ible) | Quantity/ Total | Start Date | End Date | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| Surgery | Outpatient Hospital or | r ASC Inpatien | t: Yes | No | | | | | | |
| Informatio | Date: | Admit D | Admit Date: Discha | | | arge Date: | | | | |
| Chart | notes attached. Second | page attached for a | additional C | PT/HCP0 | Cs. OTHE | R IMPORTA | NT 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 Clinical Engagement and other 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.