UMPQUA HEALTH ALLIANCE

A Coordinated Care Organization

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

PRIOR AUTHORIZATION FORM
Medications

☐ ***RETRO*** (procedure has already been performed) DATE OF SERVICE _____/_____/_____

☐ ***RUSH*** 24 hours (patient's health is at immediate risk i.e. loss of life, limb, or eyesight imminent. ***By selecting the RUSH review and submitting this form, I certify that applying the 72 hour standard review time may seriously jeopardize the life or health of the member or the member's ability to regain maximum function. Please include an explanation of medical necessity for the rush in the Statement for Medical Necessity area below***

☐ ***STANDARD*** 72 hours

CHART NOTES AND/OR LABS ARE REQUIRED TO BE SUBMITTED WITH ALL REQUEST

Date of Request:		Patient Name:	
Requesting Provider:		Patient ID Number:	
NPI (Required for Payment):		Patient DOB:	
Contact Person:		PCP:	
Telephone:		Pharmacy Name:	
Fax Number:			

Diagnosis Codes: **A primary diagnosis code is required for any request to be processed. Please provide a description for each diagnosis listed.*

Primary Dx Code:		Supporting Dx:		Supporting Dx:	
Description:		Description:		Description:	

Medication Requested:	Strength:	Directions:

Medication(s) Already Tried:

1. _____ 2. _____ 3. _____

Statement of Medical Necessity:

Fields in RED are required fields

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.