

UMPQUA HEALTH ALLIANCE  
**Prior Authorization Form**



MEDICAL/DME/MENTAL HEALTH & SUD

Note: Supporting documentation is required to be submitted with all requests.

Medical & DME	Substance Use Disorder (SUD)	Behavioral Health
<input type="checkbox"/> <b>Skilled Nursing Facility</b> 2 business days  <input type="checkbox"/> <b>Standard</b> 7 days  <input type="checkbox"/> <b>Expedite - 72 hours</b> (member's health is at immediate risk i.e. loss of life, limb, or eyesight imminent)  Reason: _____	<input type="checkbox"/> <b>Detoxification</b> 2 business days  <input type="checkbox"/> <b>Residential Treatment</b> 2 business days  <input type="checkbox"/> <b>Medical Assisted Treatment (MAT)</b> 2 business days	<input type="checkbox"/> <b>Inpatient or Residential</b> 72 hours  <input type="checkbox"/> <b>Standard</b> 7 days  <input type="checkbox"/> <b>Expedite - 72 hours</b> (member's health is at immediate risk i.e. loss of life, limb, or eyesight imminent)  Reason: _____
<input type="checkbox"/> Retro Authorization - 7 days	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Retro Authorization - 7 days

**Member Information**

First Name: \_\_\_\_\_  
 Last Name: \_\_\_\_\_  
 DOB: \_\_\_\_\_  
 ID: \_\_\_\_\_

**Referring Provider Information**

Name: \_\_\_\_\_  
 Phone: \_\_\_\_\_  
 Fax: \_\_\_\_\_  
 NPI: \_\_\_\_\_  
 Address: \_\_\_\_\_

Credentials

<input type="checkbox"/> MD	<input type="checkbox"/> DO	<input type="checkbox"/> PhD
<input type="checkbox"/> CADC	<input type="checkbox"/> LMFT/I	<input type="checkbox"/> LCSW/I
<input type="checkbox"/> LPC/I	<input type="checkbox"/> PSY	<input type="checkbox"/> PMHNP
<input type="checkbox"/> Other: _____		

**Submitter Information**

Name: \_\_\_\_\_  
 Clinic/Office: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
 Email: \_\_\_\_\_

**Delivering Provider Information**

Name: \_\_\_\_\_  
 Phone: \_\_\_\_\_  
 Fax: \_\_\_\_\_  
 NPI: \_\_\_\_\_  
 Address: \_\_\_\_\_

Credentials:

<input type="checkbox"/> MD	<input type="checkbox"/> DO	<input type="checkbox"/> PhD
<input type="checkbox"/> CADC	<input type="checkbox"/> LMFT/I	<input type="checkbox"/> LCSW/I
<input type="checkbox"/> LPC/I	<input type="checkbox"/> PSY	<input type="checkbox"/> PMHNP
<input type="checkbox"/> Other: _____		



