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
☐ **Skilled Nursing Facility** *2 business days*	☐ **Detoxification** *2 business days*	☐ **Inpatient or Residential** *72 hours*
☐ **Standard** *7 days*	☐ **Residential Treatment** *2 business days*	☐ **Standard** *7 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: _____
☐ **DME repairs -** *72 hours (no extensions allowed)*		
☐ Retro Authorization - *7 days*	☐ Other: _____	☐ Retro Authorization - *7 days*

Member Information

First Name:

Last Name:

DOB:

ID:

Submitter Information

Name:

Clinic/Office:

Phone: Fax:

Email:

Referring Provider Information

Name:

Phone:

Fax:

NPI:

Address:

Credentials ☐ MD ☐ DO ☐ PhD ☐ CADC ☐ LMFT/I ☐ LCSW/I ☐ LPC/I ☐ PSY ☐ PMHNP ☐ Other: _____

Delivering Provider Information

Name:

Phone:

Fax:

NPI:

Address:

Credentials: ☐ MD ☐ DO ☐ PhD ☐ CADC ☐ LMFT/I ☐ LCSW/I ☐ LPC/I ☐ PSY ☐ PMHNP ☐ Other: _____

Phone: 541-672-1685
Fax: 541-677-5881
Email only when fax is unavailable

Email:
PriorAuthorizations @umpquahealth.com

Website:
www.umpquahealth.com

Address:
3031 NE Stephens Street,
Roseburg, OR 97470

Procedure/Service Facility Information

Name: NPI: Fax:

Network Status*	Place of Service*	Financial Arrangement	Residential & Inpatient
☐ **In-Network** Requires explanation why request not loaded on CIM provider portal ☐ **Out-of-Network (OON)** Requires document for justification to be seen OON.	☐ **Hospital/ASC** ☐ **In-Office** ☐ **Residential** ☐ **Inpatient** Hospital Admit	☐ **Single Case Agreement** Non-DME Services Only ☐ **Specialty Financial Arrangement** DME Only ☐ **Accept DMAP Rates** *Default if no other selection*	**Admit Date:** _____ **Discharge Date:** _____

Diagnosis Code(s)

Primary:* Secondary: ☐ Initial Assesment

Procedure Code(s)

CPT/HCPC	Name/Description	Qty	Total	Start Date	End Date

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Procedure/Service Facility Information - *Continuation*

Name: NPI: Fax:

Additional Info	**Financial Arrangement**

- ☐ Additional page of codes attached
- ☐ Chart notes attached
- ☐ Psychological Evaluation form attached *(if applicable)*
- ☐ Other important information

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.

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