Advanced Health
289 LaClair St, Coos Bay, OR 97420
Voice: 541-269-7400 • 800-264-0014
Fax: 541-269-7147 • TTY: 877-769-7400

Physician Authorization Request

****Expedited Request: By selecting expedited request, you are implying that following a standard timeframe could seriously jeopardize this members' life or health. (A retro request is not an expedited request)**

Is this an Expedited request: Yes ☐ No ☐

• Fax Completed Form and chart notes to 541-269-7147 *PLEASE NOTE: INCOMPLETE FORMS WILL NOT BE PROCESSED*

Check box if member has Special Healthcare Needs (SHCN) ☐

Member Name: ______________________________ Medicaid ID #: ___________________ DOB: ____/____/____

Requesting Provider: ___________________________ PCP ☐ Specialist ☐ Other ☐

Provider's Phone Number: _______________________ Provider's Fax Number: _____________________________

PRIMARY ICD-10 Code: _________________________ Other Related ICD-10 Codes: ____________, _____________

Is this a retro-active request: ☐ Yes ☐ No If "Yes", enter the date of service: ____/____/____

****You must attach chart notes/operative report from that date.**

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REFERRALS:

Specialist Name: ____ Number of visits requested: ________________________

Specialist Address: ____

Specialist Phone Number: _________________________________ Specialist Fax Number: ____________________________

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SURGERY/THERAPEUTIC PROCEDURE: ******Sleep Study requests require an overnight oximetry report******

Members must be smoke-free for 4 weeks prior to most non-emergent surgeries. Date Member stopped smoking: ____/____/____
(Refer to Ancillary Guideline A4 on the Prioritized List for details and exceptions)

Submit results from one of the following: ☐ Urine Cotinine ☐ Anabasine or anatabine ☐ Exhaled Carbon Monoxide

CPT/HCPCS Code(s) for procedure/service: ____________, ____________, ____________, ____________, ____________

Service / Procedure Location: ☐ Provider Office ☐ Ambulatory Surgery ☐ Outpatient Hospital ☐ Inpatient Hospital

Facility Name: ____

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Comments:

Person Completing Form: ____

Contact Person:______________________________________ Phone:______________________ Fax:______________________

Date: ____/____/____

Disclaimer: Prior Authorization does not guarantee payment. Criteria is based on member eligibility on date of service, contract terms, and compliance with OAR rules, regulations and policies of CMS and Advanced Health.
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