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

Instructions to Complete Therapeutic Service Authorization Request For *Physical Therapy, Speech Therapy, Occupational Therapy, Chiropractic, Acupuncture, Naturopathy, Osteopathy, etc.*

- Provider is responsible for submitting all information in the top portion of the "Therapeutic Service Authorization Request" form along with required documentation.
- Initial therapy evaluations do not require prior authorization, unless provided by an out-of-area provider in which a referral is required.
- **Required Documentation:**
  - Prescribing Provider current prescription or signed order - MD Referral
  - Evaluation and Treatment Plan with supportive tools (ex: Oswestry)
  - PCP note, Specialist Note, Other diagnostic testing results; all of these items are optional
- Fax completed form and documentation to Advanced Health's Medical Management Department at (541) 269-7147.
- If you have questions regarding this form or other related questions, please contact Advanced Health's Medical Management Department at (541) 269-7400.

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Therapeutic Service 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*

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

Performing Provider: __________________________ PCP ☐ Specialist ☐ Other ☐

Performing Provider NPI#: __________________________

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

Prescribing Provider: ___________________________ PCP: ___________________________________

Prescribing Provider NPI#: __________________________

Requested Dates: ____/____/____ to ____/____/____

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.**

Item/Service Requested	Codes and Applicable Modifiers	# of Visits Requested

Required Documents Attached?: ☐Yes ☐No (EX: MD Notes Supporting Condition)

PLEASE NOTE: INCOMPLETE FORMS WITHOUT REQUIRED DOCUMENTS WILL DELAY THE AUTHORIZATION PROCESS List

List Documents:

Other Information:

Person Completing Form: ____

Phone:_______________________ Fax:_____________________ Date ____/____/____

Disclaimer: Prior Authorization does not guarantee payment. Depends on patient eligibility on date of service, contract terms, and compliance with rules, regulations and policies of DMAP, Medicare and Advanced Health as applicable.