AdvancedHealth
Bridging the Future of Healthcare
A Coordinated Care Organization

Advanced Health
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PRIOR AUTHORIZATION FORM

Fax: (541) 269-7147
Email: Authorizations@advancedhealth.com

SUPPORTING DOCUMENTATION IS REQUIRED TO BE SUBMITTED WITH ALL REQUESTS

Standard	Retroactive	Expedited
☐ **Standard** – 7 days ☐ **Skilled Nursing Facility** - 2 business days ☐ **DME**	☐ **Retroactive** - Cannot be considered for STAT/EXPEDITED review **Requested Date of Service:**_____ Was a claim already submitted and denied for no PA? Yes ☐ **STOP** Follow Claims Appeal Process No ☐ Please select reason for retro request: ☐ Insurance change (office unaware) ☐ Emergency (documentation must support) ☐ Other; please include all relevant documentation to support.	☐ **Expedite** – 72 hours (member's health is at immediate risk, i.e. loss of life, limb, or eyesight). ****A routine appointment/treatment is not a valid expedited request, even if scheduled within a short time**** ☐ Repair of complex rehabilitation technology **Expedited Justification (Required):**

Fields listed below in RED are required fields. Failure to provide the required information may cause a delay in authorizations.

☐ SHCN ☐ 2nd Opinion

Member Information

First name:	Last name:	DOB:	ID:

Submitter Information

Name:	Clinic/Office:	Phone: +Ext.	Fax:

Referring Provider Information

Name:	Phone:	Fax:

NPI:

Address:

Credentials: ☐ MD ☐ DO ☐ Other:

Relation to Member: ☐ PCP ☐ Other:

Servicing Provider Information

☐ (check if same as above provider)

Name:	Phone:	Fax:

NPI:

Address:

Credentials: ☐ MD ☐ DO ☐ Other:

Quantity of visits for referral requests:

Procedure/Service Facility Information

Name & NPI:

Network Status

☐ In-Network
☐ Out-of-Network (OON)
**Requires documentation for reason to be seen OON:

Place of Service

☐ Provider Office
☐ Ambulatory Surgery Center (ASC)
☐ Outpatient
☐ Inpatient (Hospital)

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.

**If member has SHCN, or if this request is a 2nd opinion or a wheelchair repair request, please indicate this in the "Member Information" bar above

ICD-10 Diagnosis Code(s)

Primary:	Secondary:

Procedure Code(s) (use 2nd page if necessary)

CPT/HCPC	Modifiers	Dose/QTY	Additional Info (Optional): descriptions, extra CPT codes, etc.