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 Ancillary Service Authorization Request

For Durable Medical Equipment (DME) or Oral Enteral Supplements

- Provider is responsible for submitting all information on the form.
- This form is used for submitting prior authorization requests only. For Referral/PA physician services use the "Physician Referral/Prior Authorization Request" form.
- **Required Documentation:**

  DME:
  - DME requiring Certificates of Medical Necessity (CMN's) can be submitted with the dispensing RX. The request will be pended waiting the receipt of CMN or other information as requested.

  Oral Enteral Supplements:
  - Criteria letter must be submitted with request as well as the prescription. Units submitted must be in calories, not cans per day.
- Disclaimer: Approval does not assure payment, which also depends on patient eligibility on date of service, contract terms, and compliance with rules, regulations and policies of Advanced Health and/or OHA as applicable.
- 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.

To complete form, please follow these instructions:

Requesting Provider:	Enter the name of the provider that is submitting the request
Phone #:	Enter the phone of the requesting provider
Fax #:	Enter the fax number of the requesting provider
Member Name:	Enter the full name of the OHP Member, including middle initial, if known
Member ID#:	(**Required field**) Enter the Member's Advanced Health ID#
DOB:	(**Required field**) Enter the Member's date of birth
Prescribing Provider:	Enter the physician who prescribed the equipment
PCP:	Enter the PCP for the Advanced Health member, if known. Leave blank if unknown.
Requested Dates:	Enter the requested dates to provide equipment or services.
ICD-10 Code(s):	**(Required field ≥ 10-01-2015)** Enter the ICD-10 codes for the diagnosis (es) that are related to the service being requested. Diagnoses must be coded to the highest level of specificity.
Item/Service Requested:	Enter the description of the item. (e.g. pant liners)

Codes and applicable modifiers:	Enter the valid HCPCS code for the item requested and modifier. Modifier for contracted items as in contracts or for Purchase Items = NU, Rental Items = RR
Quantity Requested:	Enter quantity of item or service requested.
Unit of Measure:	Enter units in accordance as utilized in billing process. (e.g. per box, each, 100 calories or per pair)
Documents attached:	Mark the appropriate box to indicate if the required documentation is attached. (**Required documentation = See above)
If "Yes", please specify:	Indicate what documentation is being submitted with the request form
Other information:	Enter any comments or in the case of non-specific HCPCS codes list the RETAILPRICE for the item. A description of the item must accompany these requests and in certain items the suppliers invoice may be requested.
Date:	Enter the date the request completed.

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Ancillary Service Authorization Request

• For questions call: 541-269-7400 • **Fax Completed Form and Records to 541-269-7147•**

****STAT requests** should be submitted for urgent conditions related to the members' health. A retro request is not a stat request. Approval will **expire in 72 hours** per Advanced Health policy.

Is this a STAT request: ☐ **Yes** ☐ **No**

Member's primary health insurance: Advanced Health OHP ☐ Dual Eligible - has Medicare and Advanced Health OHP ☐

Member Name: _____ Plan ID #: _____ DOB: ___/___/___

Requesting Provider: _____ Phone #: _____ Fax #: _____

Prescribing Provider: _____ PCP: _____

Requested Dates: ____/____/____ to ____/____/____ ICD-10 Code: _____

Item/Service Requested	Codes and applicable modifiers	Quantity Requested	Unit of Measure (UOM)	For Internal use Only

Units requested must be in accordance with standard unit of measure (UOM) utilized for billing purposes.

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

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

List Documents:

Other Information:

Person Completing Form: _____

Signature of Requesting Provider: _____ 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.