Advanced Health
289 LaClair St, Coos Bay, OR 97420
Voice: 541-269-7400 • 800-264-0014
Fax: 541-269-7147
TTY: 711 or 800-735-1232

Instructions to Complete Behavioral Health Authorization Request

- Provider is responsible for submitting all information in the top portion of the "Behavioral Health Authorization Request" form along with required documentation.
- In-network providers do not require prior authorization for outpatient visits, unless provided by an out-of-area provider in which a referral is required.
- **Required Documentation:**
  - Behavioral Health Treatment Plan
  - Behavioral Health Assessment
  - Any relevant assisting documentation.
- 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:

Performing Provider:	Enter the name of the Therapy Provider requesting authorization
Phone #:	Enter the office phone number of the Therapy Provider
Fax #:	Enter the office fax number of the Therapy Provider
Member Name:	Enter the full name of the OHP Member.
Medicaid ID #:	(**Required field**) Enter the OHP ID number for the Member
DOB:	Enter Member's date of birth
Requested Date of Service:	Enter the date(s) requested (approx. dates for OP therapy)
ICD-10 Code(s):	**(Required field**) Enter the ICD-10 codes for the diagnoses that relate to the requested services. Diagnosis must be coded to the highest level of specificity.
Item/Services Requested:	Enter the description of the therapy or modality being requested

Codes and applicable modifiers: See below

- Outpatient/*Non-Hospital* based:	Enter the CPT codes for each therapy and/or modality being requested
- Outpatient/*Hospital* based:	Enter the Revenue Code *and* correlating CPT code for each individual therapy and/or modality being requested.
Quantity Requested:	Enter the quantity of each type of therapy being requested
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.
Comments:	Add any additional information that is pertinent to the request.
Date:	Enter the date the request was completed.

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Substance Use Disorder Authorization Request

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

**** PLEASE NOTE: INCOMPLETE FORMS WILL DELAY THE AUTHORIZATION PROCESS ****

Member's Primary Health Insurance: Advanced Health OHP ☐

or Dual Eligible - has Medicare and Advanced Health OHP ☐

Member Name:_____Medicaid ID #:_____DOB:_____/____/_____

Performing Provider:_____NPI#:_____

Performing Provider Phone #:_____Fax #: _____

Detox ☐ Residential ☐ Out of Network OP visit ☐

Requested Dates:_____/____/_____ to ____/____/_____ ICD-10 Code: (Required) _____

Item/Service Requested	Codes & Applicable Modifiers	# of Visits 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.

Most current/relevant documents attached?: Yes No

Other Information:

Person Completing Form: _____

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.