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 Physical Therapy, Speech Therapy, Occupational Therapy

- Provider is responsible for submitting all information in the top portion of the "Ancillary 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
  - PT/ST/OT Evaluation
  - 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.

To complete form, please follow these instructions:

Requesting 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, including middle initial if known.
Advanced Health ID #:	(**Required field**) Enter the OHP ID number for the Member
DOB:	Enter Member's date of birth
Prescribing Provider:	Enter the name of the physician who prescribed therapy
PCP:	Enter the name of the Member's Primary Care Physician
Requested Date of Service:	Enter the date duration needed to complete the 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.
- Skilled Nursing Facility:	Enter the Revenue Code *and* correlating CPT code for each individual therapy and/or modality being requested.
- Home Health:	Please use the "Home Health Authorization Request" form
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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Ancillary Service Authorization Request

- For questions call: 541-269-7400 • Fax Completed Form and 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: _____

Performing Provider Phone #: _____ Fax #: _____

Prescribing Provider: _____ PCP: _____

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

Item/Service Requested	Codes & 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.

Documents Attached?: ☐Yes ☐No

List Documents:

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.

(Rev.3/18)