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

Hospital Length of Stay Authorization Form

• 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 **Dual Eligible - has Medicare and Advanced Health OHP**

Member Name: ____ ID #: _________________ DOB: _____/_____/_____

Date request submitted: _____/_____/_____

Name of Hospital/Facility: ____

Date of Admission: _____/_____/_____ Mark one (**required**) ☐ Observation ☐ Initial length of stay ☐ Extended length of stay

Expected length of stay or Discharge Date: _________ Admitting Diagnosis: ____

Plan of Care (Treatment/Meds., etc.)

Contact Person: ____ Phone: ______________________ Fax: _______________________

Disclaimer: Prior Authorization does not assure payment, which also 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.

For Advanced Health use only:

Disposition of Authorization:

☐ Approved as requested Initial LOS (# of days): __________ Additional LOS: __________

Additional LOS: __________ Additional LOS: __________

Medical Management Staff Signature: ____ Date: _____/_____/_____

☐ Denial reason: ____

Medical Director Signature (required for denied LOS): ___________________________________ Date: _____/_____/_____

Date Additional Notes or comments/initials:

NOA Date: _____/_____/_____ Initials: _________

D PII MC Date: _____/_____/_____

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