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

CDRC Pre Authorization Request

****Expedited Request: Expedited requests are appropriate if Standard Time Frame could seriously jeopardize a Member's life or health, or their ability to attain or maintain or regain maximum function. (A retro request is not an expedited request)**
****Is this an Expedited request: Yes ☐ No ☐**
****Justification within submitted documentation is required for Expedited processing. If your PA request does not meet Expedited criteria, it will receive Standard processing.**
JUSTIFICATION:

• Fax Completed Form and chart notes to 541-269-7147 *PLEASE NOTE: INCOMPLETE FORMS WILL NOT BE PROCESSED*

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

Performing Provider: _____ PCP ☐ Specialist ☐ Other ☐

Performing Provider NPI#: _____

Provider's Phone Number: _____ Provider's Fax Number: _____

Prescribing Provider: _____ PCP: _____

Prescribing Provider NPI#: _____

Requested Dates: ____/____/____ to ____/____/____

PRIMARY ICD-10 Code: _____ Other Related ICD-10 Codes: _____, _____

Is this a retro-active request: ☐ Yes ☐ No If "Yes", enter the date of service: ____/____/____

****You must attach chart notes/operative report from that date.**

Item/Service Requested	Codes and Applicable Modifiers	# of Visits Requested

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: _____

Phone:_____ Fax:_____ 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.