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
Encrypted email: authorizations@advancedhealth.com

Gender Dysphoria Authorization Request

For questions call: 541-269-0497 • Fax Completed Form and Records to 541-269-7147

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

*****Review process by Behavioral Health, Medical Management, and an Independent Review*****

☐ **STANDARD REQUEST** ☐ **EXPEDITED REQUEST - 72 hours (member's health is at immediate risk i.e. loss of life, limb, or eyesight imminent)** ***(Fill out Justification below:)***

****Justification within submitted documentation is required for Expedited processing. If your PA request does not meet Expedited criteria, it will receive Standard processing. 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. JUSTIFICATION:**

____

Member's Primary Health Insurance: Advanced Health OHP ☐ -OR-
Dual Eligible - has Medicare and Advanced Health OHP ☐

Member Name: ____________________________ Medicaid ID #: ______________ Member DOB: ____/____/____

Referring Provider: _______________________________ ☐ PCP ☐ Specialist ☐ Other

Referring Provider NPI#: _______________________ Provider Phone #: __________________ Fax #: _______________

Performing Provider: ______________________________ NPI #: ______________________________

Performing Provider Facility: ____________________________ Phone #: ___________________ Fax # ______________

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

Service/Procedure Location: ☐ Provider Office ☐ Ambulatory ☐ Outpatient ☐ Inpatient

Facility Name: ____

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

Item/Service Requested	CPT Codes & Applicable Modifiers (required)	# of Visits

Documentation:

☐ Initial Mental Health Assessment and/or Psychological/Psychiatric evaluation (required)

☐ Therapy Notes (2-3 required) ☐ Verification of Hormone Therapy (1 yr.)

☐ BH Letter(s): one from MH professional (hormone tx, chest surgery) (two from 2 different MH professionals for genital procedures) (assessment required)

☐ Other Information: Medical

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.8/2023)