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

Physician Authorization Request

☐ **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 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, maintain or regain maximum function.**

Expedited Justification (Required):

Fax or email documentation *PLEASE NOTE: INCOMPLETE FORMS WILL NOT BE PROCESSED*

Check box if member has Special Healthcare Needs (SHCN) ☐

Member Name: ________________________ Medicaid ID #: ________________ DOB: ____/____/____

Requesting Provider: ______________________ PCP ☐ Specialist ☐ Other ☐

Requesting Provider NPI#: ____________________

Provider's Phone Number: __________________ Provider's Fax Number: ______________________

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.**

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REFERRALS:

Specialist Name: ______________________________ Number of visits requested: __________________

Specialist Address: ____

Specialist Phone Number: ________________________ Specialist Fax Number: ____________________

Specialist NPI#: __________________________ Name of Facility: ______________________________

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SURGERY/THERAPEUTIC PROCEDURE:

For Behavioral Health referrals please use the Behavioral Health Authorization Form, IIBHT (Intensive In-Home Behavioral Health Treatment) Form, or the Gender Dysphoria Form for those types of requests

Smoking Cessation requirements vary for non-emergent surgeries. Date Member stopped smoking: __________/____/____

(Refer to the Prioritized List for details)

Submit results from one of the following: ☐ Urine Cotinine ☐ Anabasine or anatabine ☐ Exhaled Carbon Monoxide

CPT/HCPCS Code(s) for procedure/service: __________, __________, __________, __________, __________

Service / Procedure POS: ☐ Provider Office ☐ Ambulatory Surgery ☐ Outpatient Hospital ☐ Inpatient Hospital

Facility Name: ____

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Comments:

Person Completing Form: ____

Contact Person:________________________Phone:__________________Fax:__________________

Date: ____/____/____

__Disclaimer__: Prior Authorization does not guarantee payment. Criteria is based on member eligibility on date of service, contract terms, and compliance with OAR rules, regulations and policies of CMS and Advanced Health.

(Rev 02/2024)
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