

# Prior authorization request

**Important! Not for retail pharmacy drug coverage.**

Illegible or incomplete requests may be sent back for clarification or completion. All requests for authorization must be complete and include all information necessary to make medical-necessity decisions in a timely manner.

For assistance with completing this form, please call **541-768-5207** or **888-435-2396**.

**Date of request:** \_\_\_\_\_

Type of request				
<input type="checkbox"/> <b>Standard</b> <input type="checkbox"/> <b>Retrospective</b>		<input type="checkbox"/> <b>Expedited</b> – Response within 72 hours; submission indicates waiting for a decision within standard timeframe could place member’s life, health, or ability to regain maximum function in serious jeopardy.		
Health plan				
<input type="checkbox"/> Samaritan Advantage Health Plans <input type="checkbox"/> Samaritan Choice Plans <input type="checkbox"/> Samaritan Employer Group Plans <input type="checkbox"/> IHN-CCO				
Patient information				
Last name:		First name:		MI:
Patient’s primary care provider:		Date of birth: ___ / ___ / _____	Subscriber ID #:	
Provider information				
Requesting / ordering provider’s name:		Performing provider / hospital / facility / DME vendor:		
Requesting provider’s NPI:		Performing provider’s NPI:		
Requesting provider’s address:		Performing provider’s address:		
Phone:	Fax:	Phone:	Fax:	
Referral information (Complete all sections that apply)				
<input type="checkbox"/> Office <input type="checkbox"/> Outpatient services <input type="checkbox"/> DME <input type="checkbox"/> Behavioral health		<input type="checkbox"/> Inpatient / length of stay:		<input type="checkbox"/> Residential
Scheduled date: from ___ / ___ / _____ to ___ / ___ / _____		Date of scheduled appointment: ___ / ___ / _____		
ICD-10 Code	CPT/HCPC code	Modifier	# of units	Billing amount per line item (DME only)
Contact person if health plan requires additional information?				
Name:	Phone: ext:	Confidential voicemail? <input type="checkbox"/> Yes <input type="checkbox"/> No	Fax:	
Reason for request / comments / additional codes or details. (Important: attach supporting documentation)				

**Standard or retrospective requests: fax to 541-768-9766 | Expedited or Employer Group Plans requests: fax to 541-768-9787**

**Reminder: form must be complete and include supporting documentation**

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