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	
❑ **Standard** ❑ **Retrospective**	❑ **Expedited** – 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			
❑ Samaritan Advantage Health Plans	❑ Samaritan Choice Plans	❑ Samaritan Employer Group Plans	❑ 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)		
❑ Office ❑ Outpatient services ❑ DME ❑ Behavioral health	❑ Inpatient / length of stay:	❑ 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? ❑Yes ❑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 541-359-4064

Reminder: form must be complete and include supporting documentation