

# 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: **1**

## Type of request

☐ Standard **2**

☐ Retrospective **3**

☐ **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. **4**

## Health plan

☐ Samaritan Advantage Health Plans ☐ Samaritan Choice Plans ☐ Samaritan Employer Group Plans ☐ IHN-CCO **5**

## Patient information

Last name: **6** First name: **7** MI: **8**

Patient's primary care provider: **9** Date of birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ **10** Subscriber ID #: **11**

## Provider information

Requesting / ordering provider's name: **12** Performing provider / hospital / facility / DME vendor: **17**

Requesting provider's NPI: **13** Performing provider's NPI: **18**

Requesting provider's address: **14** Performing provider's address: **19**

Phone: **15** Fax: **16** Phone: **20** Fax: **21**

## Referral information (Complete all sections that apply)

☐ Office ☐ Outpatient services ☐ DME ☐ Behavioral health **22** ☐ Inpatient / length of stay: **23** ☐ Residential

Scheduled date: from \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_ **24** Date of scheduled appointment: \_\_\_\_/\_\_\_\_/\_\_\_\_ **25**

ICD-10 Code	CPT/HCPC code	Modifier	# of units	Billing amount per line item (DME only)
<b>26</b>	<b>27</b>	<b>28</b>	<b>29</b>	<b>30</b>

## Contact person if health plan requires additional information?

Name: **31** Phone: **32** Confidential voicemail? **33** Fax: **34**  
☐ Yes ☐ No

## Reason for request / comments / additional codes or details. (Important: attach supporting documentation)

**35**

**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**

Samaritan Health Plans · InterCommunity Health Network · [samhealthplans.org/Providers](http://samhealthplans.org/Providers)

155216 0923

# Prior authorization request form instructions

1. Enter the date form was sent for review.
2. Check if authorization is a standard request.  
(A request for services that will take place after the submission of this form).
3. Check if authorization is a retrospective request.  
(A request for services that have taken place prior to the submission of this form).
4. Check if service meets expedited criteria.
5. Indicate which health plan the member has.
6. Enter member's last name.
7. Enter member's first name.
8. Enter member's middle initial.
9. Enter member's primary care providers (PCP) name.
10. Enter member's date of birth (DOB).
11. Enter member's subscriber ID #.
12. Enter the requesting/ordering provider's name.
13. Enter the requesting provider's National Providers Identifier (NPI). (This should match the NPI used to bill on the claim).
14. Enter the requesting provider's address.  
(This should match the NPI provided in Box 14).
15. Enter requesting provider's contact phone #.
16. Enter requesting provider's fax #.
17. Enter performing provider/hospital/facility/DME vendor's name.
18. Enter performing providers National Providers Identifier (NPI). (This should match the NPI used to bill on the claim).
19. Enter performing provider's address. (This should match the NPI provided in Box 18.)
20. Enter performing provider's phone #.
21. Enter performing provider's fax #.
22. Check appropriate box for type of service.
23. Only needed if inpatient. Indicate if inpatient or residential and the expected length of stay.
24. Check box if service yet to be scheduled. Enter proposed date span.
25. Only enter date if service has already been scheduled.
26. List out all ICD-10 diagnosis codes pertaining to services requested. (If more room is needed use box 35).
27. List out all CPT/HCPC codes requested on this authorization. (If more room is needed use box 35).
28. List any modifiers required for the corresponding CPT/HCPC code on the same line.
29. List the # of units needed for the corresponding CPT/HCPC code on the same line. (Note: verify # of units for all injectable drugs matches how code is billed out).
30. Only for DME, list the billed amount per line item.
31. Contact person's name.
32. Contact person's phone #.
33. Check if voice mail is confidential.
34. Contact person's fax #.
35. Add any additional ICD-10/CPT/HCPC and any additional comments/notes or details required.

# 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>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.		
<input type="checkbox"/> <b>Retrospective</b>				
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 541-359-4064**

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

Samaritan Health Plans · InterCommunity Health Network · [samhealthplans.org/Providers](http://samhealthplans.org/Providers)

155216 0923