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)
26	27	28	29	30

Contact person if health plan requires additional information?			
Name: 31	Phone: ext: 32	Confidential voicemail? ❑Yes ❑No 33	Fax: 34

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

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.

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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)

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