



# Facility Based Behavioral Health

Inpatient, Residential, Partial Hospitalization and IOP  
Prior Authorization Request



**\*\*Chart Notes Required\*\***

Please fax to Behavioral Health: 503-574-8192 | Questions please call: 503-574-6400 NOTE: This form cannot be used to request ABA therapy, TMS or outpatient behavioral health services.

Member Information		
Last Name:	First Name:	
Insurance ID #:	DOB:	Phone:
Address:	Date of Admit	Date Span Requested:
<b>Primary Care Physician (PCP):</b>		
<b>Requesting Provider:</b>		TIN#:
Address:		NPI#:
<b>Attending Provider:</b>		TIN#:
Address:		NPI#:
<b>Treating Facility:</b>		TIN#:
Address:		NPI#:
<b>Requested Level of Care/ASAM Level:</b>		
<b>IOP &amp; Partial Hospitalization</b> # of Units being requested _____ # of Days per Week being requested _____		
ICD-10 Code(s):	Revenue/CPT Code(s):	
<input type="checkbox"/> Mental Health <input type="checkbox"/> Substance use		
<u>Expedite</u> - defined as member's life, health or ability to regain maximum function is in serious jeopardy if determination is not made in the standard timeframe. <b>Request must include supporting documentation to substantiate an expedited review.</b> Explanation Required:		
<u>In-Network Benefits</u> : <b>Request must include supporting documentation to substantiate why services cannot be provided by an in-network provider/facility. Please also submit facility's state license to provide level of care/service requested.</b> Explanation Required:		
<b>**REQUIRED** Utilization Review Contact Information:</b>		
Name:	Phone #:	Fax#:

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