HEALTH SERVICES PREAUTHORIZATION REQUEST FORM

Please fax completed form with chart notes to: 541.225.3683

A determination notice will be mailed and/or faxed to the requesting provider, facility, and patient.

- Service occurring within 72 hours of request should be marked "URGENT."
- PacificSource Administrators responds to preauthorization requests within five working days
- **Incomplete requests will delay the preauthorization process.**
- Please include pertinent chart notes to expedite this request.

REQUESTING PROVIDER CONTACT INFORMATION

Date: ______________________ Contact person: ______________________

Phone: ______________________ Extension: __________ Fax: __________

PATIENT INFORMATION

Last name: ______________________ First name: ______________________

DOB: ______________________ Member number: ______________________

PROCEDURE INFORMATION

CPT / HCPCS code and description: ______________________

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Notes: ______________________

Diagnosis code and description: ______________________

Retrospective review? ☐ Yes ☐ No Dates of service: ______________________ ☐ To be scheduled

☐ Inpatient ☐ Residential Estimated length of stay (number of days): ______________________

☐ Outpatient ☐ Office ☐ Home Durable medical equipment: ☐ Rental ☐ Purchase Cost $__________

PROVIDER INFORMATION

Ordering provider or surgeon: ______________________

Address: ______________________

City/State/Zip: ______________________ Tax ID: __________

Phone: ______________________ Fax: ______________________

Place of service, vendor, or facility: ______________________

Address: ______________________

City/State/Zip: ______________________ Tax ID: __________

Phone: ______________________ Fax: ______________________

PacificSource Administrators Health Services Department
13010 SW 68th Parkway, Suite 140, Tigard, OR 97223
503.598.8908 ● Toll-free 800.473.0509 ● Confidential Fax 541.225.3683