HEALTH SERVICES PREAUTHORIZATION REQUEST FORM

Please fax completed form and chart notes to: (208) 333-1597

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

- PacificSource responds to preauthorization requests within two (2) working days.
- Requests received after 3:00 p.m. are processed the next work day.
- Incomplete requests will delay the preauthorization process.
- Please include pertinent chart notes to expedite this request.

REQUESTING PROVIDER CONTACT INFORMATION

Contact person: ______________________________

Date: ______________ Phone: (____) ______________ Fax: (____) ______________

PATIENT INFORMATION

Last name: ______________ First name: ______________

DOB: ______________Member #: ______________

PROCEDURE INFORMATION

CPT / HCPCS procedure codes: ______________

Description: ______________

Description: ______________

Diagnosis code and description: ______________

☐ To be scheduled   Dates of service: ______________

☐ Outpatient ☐ Inpatient   Requested length of stay: ________ days

Assistant surgeon requested? ☐ Yes ☐ No   Is this a retrospective request? ☐ Yes ☐ No

PROVIDER INFORMATION

Ordering physician/provider: ______________

Office address where preauthorization should be sent: ______________

City/State: ______________ Tax ID: ______________

Fax #: (____) ______________ Phone: (____) ______________

Place of service or vendor name: ______________

Office address where preauthorization should be sent: ______________

City/State: ______________ Tax ID:______________

Fax #: (____) ______________ Phone: (____) ______________

Health Services Department
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