Health Net Oregon Commercial Plan
Request for Prior Authorization

Instructions: Use this form to request prior authorization for POS, PPO and EPO.
Type or **print;** complete all sections. **Attach sufficient clinical information** to support medical necessity for services or your request may be delayed.
Health Net Health Plan of Oregon, Inc. (Health Net) will provide notification of decision by phone, mail, fax or other means.
Washington requests for immediate review (any request for approval of an intervention, care or treatment where passage of time without treatment would, in the judgment of the provider, result in an imminent emergency room visit or hospital admission and deterioration of the member's health status) should be requested by telephone at 1-888-802-7001.

Fax the completed form to the Prior Authorization Department at 1-800-495-1148.

MEMBER INFORMATION

Member name: Last First MI Date of birth (Mo/Day/Yr)

Subscriber #

Check appropriate box.

Product: PPO (POS tier 2) ☐ **Out-of-network (POS tier 3)** ☐ **EPO (tier 2)** ☐
Other insurance/policy # _____ **Work-related** ☐ **Auto-accident** ☐

Designate type of request. Check appropriate box.

- ☐ **Elective** for routine, non-urgent services
- ☐ **Expedited/Urgent:** Needed urgently, if not, could seriously jeopardize the life/health or ability of member to regain maximum function or, in your opinion, would subject member to severe pain that cannot be adequately managed without the service/treatment requested below.
  Explain clinical necessity for urgent/expedited request _____
- ☐ Notification only, for dialysis or prenatal maternity care EDC_____
- ☐ Confidential request: Member/provider requests confidentiality. Service-confirmation letter to member will not be mailed to the member.
- ☐ Post-service request.

Designate service requested. Check appropriate box.

- ☐ Office procedure
- ☐ Outpatient service/surgery
- ☐ Inpatient services
- ☐ Orthotics and/or prosthetics
- ☐ Clinical trial
- ☐ Other_____

Anticipated date of service: _____

- ☐ DME
- ☐ Initial outpatient rehabilitative ___/habilitative ___services (PT, OT, ST)
- ☐ Initial home health: Is member home bound? Yes ___ No ___
- ☐ Continued outpatient rehabilitative ___/habilitative ___ services (HH/PT/OT/ST)
  Remaining authorized visits? ____ Does plan have volume limits? ___
  Has member used or will use their last visit within next 24 hours? Yes No

PROVIDER INFORMATION

Requesting/Ordering Provider Information			**Servicing Provider – Where will member receive services?**	
First and last name of requesting provider		Tax ID/NPI	Name of hospital or provider of services/product (no abbreviations)	
Address			Tax ID # of above	National Provider Identifier of above
City/State/ZIP code:			Address	
Area code	Telephone # + ext.	Fax #	City/State/ZIP code:	
Requesting/ordering contact name (REQUIRED)		Telephone # + ext	Area code	Telephone # of above + ext.
Name of primary care physician (PCP) (if applicable)			Assistant surgeon required? ☐ Yes ☐ No Name Tax ID/NPI	
Area code	Telephone # + ext.	Fax #	Anesthesiologist required? ☐ Yes ☐ No	

CLINICAL INFORMATION

ICD-10 code(s) (REQUIRED)	Diagnosis description		Date of onset/injury
CPT code(s) (REQUIRED)	# of visits	Describe service requested (Note: Billed CPT codes not approved require clinical review upon submission of claim and report)	
Why is the service necessary? (Attach diagnostics, X-ray reports, progress notes, results of conservative treatment)			
Is the member terminally ill? (Life expectancy less than 6 months) ☐ Yes ☐ No N/A Is the member aware? Yes No N/A			
Signature of requesting physician			Date

Note: Provider agrees that the results of the care or treatment rendered under approved authorization shall be forwarded to the requesting physician or primary care physician named above for inclusion in the patient's medical record. Health Net uses evidence-based information and national guidelines to make authorization decisions. Contracted provider agrees to accept Health Net's payment as payment in full and will not bill the member for any amount for services rendered hereunder except for member copayments, deductibles, and coinsurances required under the member's plan. This form is not a guarantee of payment. Charges for services rendered to patients whose coverage is no longer in effect are the patient's responsibility. Patient eligibility and covered benefits must be verified at www.healthnet.com before rendering any medical services.