OREGON COMMERCIAL OUTPATIENT AUTHORIZATION FORM

Complete and **Fax** to: 800-495-1148
Transplant **Fax** to: : 833-714-3691
Customer Contact Center : 888-802-7001

☐ Request for additional units. Existing Authorization ☐☐☐☐☐☐☐☐☐☐☐☐ Units ☐☐☐☐

☐ **Standard requests -** Determination within 2 calendar days of receiving all necessary information.

☐ **Urgent requests -** I certify this request is urgent and medically necessary to treat an injury, illness or condition (not life threatening) within 72 hours to avoid complications and unnecessary suffering or severe pain.

*** INDICATES REQUIRED FIELD** X _____ URGENT REQUESTS MUST BE SIGNED BY THE REQUESTING PROVIDER TO RECEIVE PRIORITY.

MEMBER INFORMATION

*Member ID

*Date of Birth (MMDDYYYY)

Last Name, First

REQUESTING PROVIDER INFORMATION

*Requesting NPI

*Requesting TIN

Requesting Provider Contact Name

Requesting Provider Name

Phone

*Fax

SERVICING PROVIDER / FACILITY INFORMATION

↳ ☐ Same as Requesting Provider

*Servicing NPI

*Servicing TIN

Servicing Provider Contact Name

Servicing Provider/Facility Name

Phone

Fax

AUTHORIZATION REQUEST

***Primary** Procedure Code (CPT/HCPCS) (Modifier)

Additional Procedure Code (CPT/HCPCS) (Modifier)

Start Date *OR Admission Date (MMDDYYYY)

*Diagnosis Code (ICD-10)

Additional Procedure Code (CPT/HCPCS) (Modifier)

Additional Procedure Code (CPT/HCPCS) (Modifier)

End Date *OR* Discharge Date (MMDDYYYY)

Total Units/Visits/Days

*OUTPATIENT SERVICE TYPE

(Enter the Service type number in the boxes) ☐☐☐

712 Cochlear Implants & Surgery
922 Experimental and Investigational Services
205 Genetic Testing & Counseling
249 Home health
390 Hospice Services
611 Infertility Treatment
997 Office Visit/Consult
794 Outpatient Services

202 Pain Management
171 Outpatient Surgery
650 Radiation Therapy
993 Transplant Evaluation
209 Transplant Surgery
724 Transportation
427 Rehab
792 Vendor

395 Infertility
701 Speech Therapy
790 Occupational Therapy
101 Physical Therapy

DME
417 Rental
120 Purchase (Purchase Price)

ALL REQUIRED FIELDS MUST BE FILLED IN AS INCOMPLETE FORMS WILL BE REJECTED.
COPIES OF ALL SUPPORTING CLINICAL INFORMATION ARE REQUIRED. LACK OF CLINICAL INFORMATION MAY RESULT IN DELAYED DETERMINATION.

Rev. 06 06 2026
XQ-PAF-6159