Outpatient Behavioral Health
Standard Prior Authorization Request
****Chart Notes Required****

Please fax to Behavioral Health: 503-574-8110 | Questions please call: 503-574-6400

NOTE: This form cannot be used to request ABA or TMS.

Member Information		
Last Name:	First Name: Phone #:	
Insurance ID #:	DOB:	
Address:	Date of Service:	Date Span Requested:
Primary Care Physician (PCP):		
Requesting Provider:		TIN#:
Address:		NPI#:
Servicing Provider:		TIN#:
Address:		NPI#:
Servicing Facility:		TIN#:
Address:		NPI#:

Type of Service:
☐ Mental Health| ☐ Substance Abuse

Requested Item/Service:

ICD-10 Code(s):	CPT Code(s):

Requested Services:
☐ Office Visits, # of visits: _____| ☐ Diagnostic | ☐ Facility Auth Only | ☐ DME | Other _____

In-Network Benefits: **Request must include supporting documentation to substantiate why services cannot be provided by an in-network provider/facility.** ☐ New Patient ☐ Established Patient | Date last seen _____
Explanation Required:

****REQUIRED** Contact Information**:		
Name:	Phone #:	Fax#: