



# MEDICARE BEHAVIORAL HEALTH OUTPATIENT AUTHORIZATION OREGON

Expedited Requests **Call:** 1-833-616-0645  
Standard Requests **Fax:** 1-833-505-1300  
Behavioral Health Requests **Fax:** 1-833-320-2896

**For Standard requests, complete this form and FAX to the appropriate department.** Determination made as expeditiously as the enrollee's health condition requires, but no later than 72 hours days after the receipt of request.

**\* Indicates Required Field**

## MEMBER INFORMATION

Member ID \*

Last Name, First

Date of Birth \*

(MMDDYYYY)

## 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)

Discharge Date (if applicable) otherwise  
Length of Stay will be based on Medical Necessity

(MMDDYYYY)

Additional Diagnosis Code

(ICD-10)

**OUTPATIENT SERVICE TYPE \***

(Enter the Service type number in the boxes)

- 510 BH Medical Management
- 530 BH Partial Hospitalization Program (PHP)
- 512 BH Community Based Services
- 513 BH Crisis Psychotherapy
- 514 BH Day Treatment
- 515 BH Electroconvulsive Therapy
- 518 BH Mental Health /Chemical Dependency Observation
- 519 BH Outpatient Therapy
- 520 BH Professional Fees
- 521 BH Psychological Testing
- 522 BH Psychiatric Evaluation

**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.**

**Disclaimer:** An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

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