



REFERRAL/PRIOR AUTHORIZATION REQUEST FORM

WVCH Fax: 503-581-7417
Salem Clinic: Fax: 503-371-4175

MEMBER ID:		REFERRING PROVIDER NAME:		
MEMBER NAME:		MEMBER PHONE:	MEMBER DOB:	
OFFICE FAX:		CONTACT PERSON at requestors office :		
OFFICE PHONE:		SERVICE DATE FROM:	TO:	
ICD (10) CODE(s):	Primary:	Secondary:	Tertiary:	NUMBER OF VISITS/UNITS:

R E F E R R A L	PCP REFERRAL TO SPECIALTY CARE:			
	REFERRED TO PROVIDER:	SPECIALTY:	IN NETWORK OUT OF NETWORK	
	REASON FOR OUT-OF-NETWORK REQUEST: (Medical Necessity Only)			
	CONTACT PERSON:	PHONE:	FAX:	
	Consult only		Consult & Treat	Allow Diagnostic

P R I O R A U T H	REQUEST FOR TREATMENT THAT REQUIRES PRIOR AUTHORIZATION: Please include clinical notes/documentation of medical necessity for requested service. *If requesting continued therapy service, please include initial and/or updated evaluation and progress notes.			
	FACILITY/VENDOR:	Outpatient Inpatient	Est. Length of Stay (Hospital or SNF):	
	FACILITY PHONE:		FACILITY FAX:	
	REQUESTED SERVICE (CPT):	Primary:	Secondary:	Tertiary:
	Therapy only: <input type="checkbox"/> Initial Request <input type="checkbox"/> Continuing—Last DOS :			Visits Used:
	REASON FOR REQUEST:			

M E D I C A T I O N P A	REQUEST FOR MEDICATION THAT REQUIRES PRIOR AUTHORIZATION OR IS NON FORMULARY: Please include clinical notes/documentation of medical necessity or previously tried/failed medication(s). WVCH RX FAX: 503-581-7353 Eff 1/1/18 fax all RX PA to WVCH			
	MEDICATION:	DOSE:	DOSE FORM:	DIRECTIONS/SIG:
	QTY:	BRAND ONLY NEEDED?	RENEWAL: Y: N:	Explain Previous Tried/Failed:
	MEDICATION:	DOSE:	DOSE FORM:	DIRECTIONS/SIG:
	QTY:	BRAND ONLY NEEDED?	RENEWAL: Y: N:	Explain Previous Tried/Failed:
	MEDICATION:	DOSE:	DOSE FORM:	DIRECTIONS/SIG:
	QTY:	BRAND ONLY NEEDED?	RENEWAL: Y: N:	Explain Previous Tried/Failed:
	REASON FOR REQUEST:			

D M E	REQUEST FOR DURABLE MEDICAL EQUIPMENT THAT REQUIRES PRIOR AUTHORIZATION: Please attach clinical notes/documentation of medical necessity and CMN.		
	RENTAL	PURCHASE	CONVERT TO PURCHASE
	HCPC:		MEDICAID ALLOWABLE: \$
	CONTACT PERSON:	PHONE:	
	ORDERING PROVIDER:		

This request will be processed within the standard timeframe unless otherwise indicated. Please expedite (review within 24-72 hours) as provider determines waiting could seriously jeopardize the life or health of the member, or members ability to regain maximum function. Questions or Comments WVCH Provider Services Phone: 503-584-2150