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:

REFERRAL

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 ☐ Allow Surgery ☐ Sub Referral Authority

PRIOR AUTH

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: ☐ Initial Request ☐ Continuing—Last DOS :			Visits Used:
REASON FOR REQUEST:			

MEDICATION PA

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 SALEM CLINIC FAX: 503-371-4175

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:

DME

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