

# 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:
<b>R E F E R R A L</b>	<b>PCP REFERRAL TO SPECIALTY CARE:</b>				
	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
<b>P R I O R  A U T H</b>	<b>REQUEST FOR TREATMENT THAT REQUIRES PRIOR AUTHORIZATION:</b> 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:				
<b>M E D I C A T I O N  P A</b>	<b>REQUEST FOR MEDICATION THAT REQUIRES PRIOR AUTHORIZATION OR IS NON FORMULARY:</b> 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:	
<b>D M E</b>	<b>REQUEST FOR DURABLE MEDICAL EQUIPMENT THAT REQUIRES PRIOR AUTHORIZATION:</b> 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. <input type="checkbox"/> 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					