REFERRAL/PRIOR AUTHORIZATION REQUEST FORM

Fax completed form to (541) 956-5460 **Phone (541) 471-4208** **Toll Free (800) 471-0304**

REQUESTING PROVIDER – COMPLETE THIS SECTION:

Patient Name LAST FIRST MI			DMAP ID#
DOB	Primary Care Provider	Contact Person	
Requesting Clinic/Provider	Clinic Phone #	Clinic Fax #	
Referred To: (Provider)		Referred To: (Facility, if different)	
Services Requested ☐ Check if **2**nd opinion			
Providers Phone #	Providers Fax #	Appt/Procedure Date	
Referral Start Date	Number of Visits Requested (Check One) ☐ **2** VISITS *Preferred for Initial Requests* ☐ **3** VISITS In **3** Months ☐ **6** VISITS In **6** Months ☐ OTHER _____		
ICD10 DX Codes * **1**)_____ **2**)_____ **3**)_____ **4**)_____ **5**)_____ **Requesting provider, please submit ICD -**10** Dx codes. Include Primary, Secondary, and Related/Comorbid Dx Codes.			

Surgery/Procedure/Injectable Medication/Equipment

INSTRUCTIONS: Please list CPT (procedure code(s)) or HCPC codes requested and indicate corresponding diagnosis code number from list above.

CPT/HCPC Code	Corresponding Diagnosis POINT TO CORRESPONDING DX: EX **1**, **3**, ETC	Quantity	Description/Notes

Requesting Provider's Signature: _____ Date: _____

ATTENTION PROVIDER

Referrals are not valid until eligibility, benefits and diagnosis have been verified and referral number is assigned by PrimaryHealth. Guidelines may apply to surgery, some diagnostics and some injections. Retroactive referrals will be considered up to **30** days following the date of service.

Please note OHP guidelines allow up to **14** days to approve or deny this request. You will be notified of our decision. Please allow at least ***5*** business days for processing prior to calling the office to inquire about the status of this request. Please send relevant chart notes to expedite processing. If your request is medically urgent, please print a note on this form to alert us to your processing needs. Thank You.

PrimaryHealth of Josephine County