

**HEALTH SERVICES
PREAUTHORIZATION
REQUEST FORM**



**Please fax completed
form and chart notes to:
(541) 225-3683**

A determination notice will be mailed and/or faxed to the requesting provider, facility, and patient.

- Service occurring within 72 hours of request should be marked as URGENT.
- PacificSource Administrators responds to preauthorization requests within five (5) working days
- Incomplete requests will delay the preauthorization process.
- Please include pertinent chart notes to expedite this request.

REQUESTING PROVIDER CONTACT INFORMATION

Contact person: _____

Date: _____ Phone: (____) _____ Fax: (____) _____

PATIENT INFORMATION

Last name: _____ First name: _____

DOB: _____ Member #: _____

PROCEDURE INFORMATION

CPT / HCPCS procedure codes: _____

Description: _____

Description: _____

ICD-9 Diagnoses codes: _____

Description: _____

To be scheduled Dates of service: _____

Outpatient Inpatient Requested length of stay: _____ days

Assistant surgeon requested? Yes No Is this a retrospective request? Yes No

PROVIDER INFORMATION

Ordering physician/provider: _____

Office address where preauthorization should be sent: _____

City/State: _____ Tax ID: _____

Fax #: (____) _____ Phone: (____) _____

Place of service or vendor name: _____

Office address where preauthorization should be sent:: _____

City/State: _____ Tax ID: _____

Fax #: (____) _____ Phone: (____) _____

PacificSource Administrators • Health Services Department
13010 SW 68th Parkway, Suite 140 • Tigard, OR 97223
503.598.8908 • 800.473.0509 • Confidential Fax 541.225.3683