PacificSource Community Solutions
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Health Services Prior Authorization Request

A determination notice will be mailed and/or faxed to the requesting provider, facility, and patient. Service is typically faster through electronic submission. Please contact your Provider Service Representative for InTouch portal access information.

- Incomplete requests will delay the standard prior authorization process
- PacificSource Community Solutions responds to standard prior authorization requests within 14 calendar days.
- Please include pertinent chart notes to support this request.

Requesting Provider Contact Information

Contact person:	Date:
Phone:	Fax:

Patient Information

Patient Name: (First, M.I., Last)

DOB:	Member ID:

OHP/Medicaid ID:

Procedure Information

CPT / HCPCS Procedure Code(s)	Units / Visits Requested	Diagnosis Code(s)

Refer to Comment section on Page 2 for additional codes.

Requested Start Date:	Requested End Date:

Assistant surgeon requested? ☐ Yes ☐ No

Is this a retrospective request*? ☐ Yes ☐ No Date of service:

Provider/Place of Service Information

Ordering physician/provider:	Tax ID:

Address where prior authorization should be sent:

Phone:		Fax:
Rendering / Service Provider / Vendor:		Tax ID:
Does provider/vendor accept OHA rates?	☐ Yes ☐ No	
Address where prior authorization should be sent:		
Phone:		Fax:
Additional Notes/Comments:		