PacificSource Community Health Plans
2965 NE Conners Avenue, Bend, OR 97701
541.385.5315 888.863.3637
Medicare.PacificSource.com

Health Services Prior Authorization Request Form

Please fax completed form and chart notes to:
OREGON: (541) 382-2952 IDAHO: (208) 395-2697

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

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

REQUESTING PROVIDER CONTACT INFORMATION

Name:	Date:
Phone:	Fax:

PATIENT INFORMATION

Patient Name: (First, M.I., Last):	
DOB:	Member ID:

PROCEDURE INFORMATION

CPT / HCPCS procedure codes:

Description:

Diagnosis codes:

Description:

To be scheduled: ☐ Dates of service/admit:_____

☐ Outpatient: Requested number of visits: _____
☐ Inpatient: Requested length of stay: _____ days

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

PROVIDER/PLACE OF SERVICE INFORMATION

Ordering physician/provider:	Tax ID:
Address where prior authorization should be sent:	
Phone:	Fax:
Place of service or vendor name:	Tax ID:
Address where prior authorization should be sent:	
Phone:	Fax: