ASURIS NORTHWEST HEALTH

Pre-authorization Request Form
Medicare Home Health
Fax: 1 (855) 207-1209
Mail to: PO Box 1271, WW5-53
Portland, OR 97207-1271

Instructions: This form should be completed and filled out by the requesting provider. Prior to completing this form, please confirm the patient's benefits, eligibility and whether pre-authorization is required.

Expedited request. I attest that this request meets the definition indicated below by checking the expedited request box. ☐ Fax to 1 (855) 240-6498.

Expedited is defined as: When the member or his/her physician believes that waiting for a decision within the standard timeframe could place the member's life, health or ability to regain maximum function in serious jeopardy.

SECTION 1 – PATIENT INFORMATION

Patient Name (Last)	First	MI	Patient's Phone #

Patient's Asuris Member ID #	Group #	Date of Birth

SECTION 2 – PROVIDER INFORMATION

Requesting/Prescribing Provider Name		Tax ID #	
NPI #	**Office Phone #**	**Confidential Voice Mail** ☐ Yes ☐ No	**Fax #**
Mailing Address		**City**	**State** / **ZIP Code**
Provider Specialty		**Email Address**	

Who should we contact if we require additional information?

Name	Phone # Ext.	Confidential Voice Mail ☐ Yes ☐ No	Fax #

If a physician reviewer needs a peer to peer discussion before a determination, please provide the treating provider's direct phone number and availability for the next 3 to 5 days.

Phone #: Ext:	Date: Time:	Date: Time:	Date: Time:

Home Health Agency Name		Tax ID #	NPI #
Mailing Address		**Fax #**	

City	State	ZIP Code	Phone # Ext.	Confidential Voice Mail ☐ Yes ☐ No

Email Address	Outcome and Assessment Information Set (OASIS) and Medication Reconciliation Form Included? ☐ Yes ☐ No

SECTION 3 – PREAUTHORIZATION REQUEST

Dates of Service _____

Episode Requested: ☐ 1 (Day 0-60) ☐ 2 (Day 61-120) ☐ 3+ (Day 120 and beyond)

Please provide all diagnosis, CPT or HCPCS codes and their descriptions.

Diagnosis code(s) and description(s)	CPT or HCPCS code(s) and description(s)
Primary:	
Second:	
Third:	

SECTION 4 – DOCUMENTATION SUBMISSION

Submit the following documentation, as appropriate, with this request:

- Outcome and Assessment Information Set (OASIS)
- Medication Reconciliation Form

  AND
- History and physical
- Lab/radiology/testing results
- Current symptoms and functional impairment
- Treatment history and any other information such as chart notes that support medical necessity for the request.

Any other supporting documents you would like considered, such as letters from outpatient providers, etc.