AllCare PEBB
CareSource

PRIOR AUTHORIZATION/DME REQUEST

☐ STANDARD (within 14 calendar days)

☐ URGENT (varies depending on line of business: within 72 hours – 2 business days)

** **REQUIRES PROVIDER JUSTIFICATION** ____________________

INSURANCE ☐ AllCare CCO ☐ AllCare PEBB ☐ CareSource

MEMBER
First name ____________ Last name ____________
DOB ____________ ID # ____________

ORDERING PROVIDER
Full name ____________ Provider fax ____________

RENDERING FACILITY
Name ____________ NPI ____________
Phone ____________ FAX ____________

SERVICE INFORMATION
Requested Item/procedure(s) ____________
Diagnosis Code ____________ Diagnosis Code ____________
Diagnosis Code ____________ Diagnosis Code ____________

HCPC/CPT Code ____________ MOD ____________ Units ____________
HCPC/CPT Code ____________ MOD ____________ Units ____________
HCPC/CPT Code ____________ MOD ____________ Units ____________
HCPC/CPT Code ____________ MOD ____________ Units ____________

Start date ____________ End date ____________
Date of Service ____________

☐ Inpatient ☐ Outpatient ☐ In-Office

PREPARED BY
Name ____________
Clinic name ____________ Date ____________
Phone ____________ FAX ____________

FAX COMPLETED FORM WITH SUPPORTING DOCUMENTATION (RX/CMN IF APPLICABLE) TO 541-471-4128.

** Payments of benefits is contingent upon eligibility, prior authorization requirements, final diagnosis from the provider (OHP), and exclusions and limitations of the contract.

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