Facility Based Behavioral Health

Providence Health Plan

Inpatient, Residential, Partial Hospitalization and IOP
Prior Authorization Request

****Chart Notes Required****

Providence Medicare Advantage Plans

Please fax to Behavioral Health: 503-574-8192 | Questions please call: 503-574-6400 NOTE: This form cannot be used to request ABA therapy, TMS or outpatient behavioral health services.

Member Information		
Last Name:	First Name:	
Insurance ID #:	DOB: Phone:	
Address:	Date of Admit	Date Span Requested:

Primary Care Physician (PCP):	
Requesting Provider:	TIN#:
Address:	NPI#:
Attending Provider:	TIN#:
Address:	NPI#:
Treating Facility:	TIN#:
Address:	NPI#:

Requested Level of Care/ASAM Level:

IOP & Partial Hospitalization # of Units being requested _____ # of Days per Week being requested _____

ICD-10 Code(s):	Revenue/CPT Code(s):

☐ Mental Health
☐ Substance use

Expedite- defined as member's life, health or ability to regain maximum function is in serious jeopardy if determination is not made in the standard timeframe. **Request must include supporting documentation to substantiate an expedited review.**

Explanation Required:

In-Network Benefits: **Request must include supporting documentation to substantiate why services cannot be provided by an in-network provider/facility. Please also submit facility's state license to provide level of care/service requested.**

Explanation Required:

****REQUIRED** Utilization Review Contact Information:**		
Name:	Phone #:	Fax#: