EDMS COVERSHEET

Use to fax documents for entry into the Oregon Medicaid Electronic Document Management System (EDMS).

From: ______________________________ **Date:** __________

Phone: ______________________________ **No. of Pages:**__________
(including this coversheet)

Document Type: Check only one box and fax to the number shown. Use a new coversheet for each transaction.

- ☐ Prior Authorization (PA) (*Also check one box below*)
  - ☐ Routine Processing – 503-378-5814
  - ☐ Urgent Processing *(3 business days)* } 503-378-3435
  - ☐ Immediate Processing *(1 business day)* } 503-378-3435

Clinical justification is required for expedited processing (summarize below). If your request does not meet Urgent or Immediate criteria, it will receive Routine processing.

- ☐ Hearing Documentation *(no central fax #)*
- ☐ Grievance Documentation *(no central fax #)*
- ☐ Correspondence – 503-378-3086
- ☐ Provider Enrollment (PE) – 503-378-3074
- ☐ Claim Documentation – 503-378-3086

Justification:____

____

For Provider Enrollment requests: Find required forms and instructions at:
www.oregon.gov/OHA/HSD/OHP/Pages/Provider-Enroll.aspx

For Prior Authorization requests and claim documentation: Find program-specific PA criteria and documentation requirements at www.oregon.gov/OHA/HSD/OHP/Pages/Policies.aspx *(click on the link for your program).*

Documentation Identification Numbers: Provider ID is required on all requests from providers. To link documents to a specific Recipient ID, PA, claim or other record in our system, enter the appropriate number(s) below. Use one character or number per box; press tab between each entry.

PE Application Tracking Number (ATN): ☐☐☐☐☐☐☐☐☐

Provider ID *(NPI or Oregon Medicaid ID)*: ☐☐☐☐☐☐☐☐☐☐

Recipient ID *(as listed on the Medical ID)*: ☐☐☐☐☐☐☐☐

Prior Authorization Number (PAN): ☐☐☐☐☐☐☐☐☐☐

Internal Claim Number (ICN): ☐☐☐☐☐☐☐☐☐☐☐☐☐

Hearings/Grievances Number (HGN): ☐☐☐☐☐☐☐☐☐

Contact Tracking Number (CTN)*: ☐☐☐☐☐☐☐☐☐☐ ☐☐ ☐☐

**For DHS/OHA staff use only: Enter the CTN to link correspondence to a specific Contact Tracking Management System (CTMS) entry. Include CTMS question number and notes number, as applicable. If the CTN is linked to a specific provider or recipient contact, also enter the Provider or Recipient ID.*

Confidentiality Notice: The information contained in this packet is confidential and legally privileged. It is intended only for use of the individual named. If you are not the intended recipient, you are hereby notified that the disclosure, copying, distribution, or taking of any action in regards to the contents of this fax - except its direct delivery to the intended recipient - is strictly prohibited. If you have received this packet in error, please notify the sender immediately and destroy this cover sheet along with its contents, and delete from your system, if applicable.

Oregon Department of Human Services

DHS/OHA Prior Authorization Request Form

Oregon Health Authority

Instructions

- **For the requested service(s) to be eligible for reimbursement,** the requesting, performing, and referring providers for the requested service must all be enrolled Oregon Health Plan (OHP) providers.
- **Complete all required fields marked in bold.** These fields are **mandatory** for processing.
- **Please attach the necessary clinical documentation for the services requested** (e.g., treatment care plan, progress notes, imaging reports). Only include documentation that directly pertains to your request. Attaching unrelated documents (e.g., all chart notes) may delay processing.
- **For specific requirements, refer to the rules and guidelines of your program** at bit.ly/ohp-rules.

I – Request information

Client name: ______________________ Client ID: __________ DOB: __________

Requesting Provider *(the office or facility requesting the service)*

Name: ______________________ Provider NPI: ______________________

Contact person: ______________________ Phone number: ______________________

Fax number: ______________________

Performing Provider

Name: ______________________ Provider NPI: ______________________

Referring Provider *(only required if different than Requesting Provider)*

Name: ______________________ Provider NPI: ______________________

PA Assignment: Type of request *(Select one)*:

- ☐ ABA-APPLIED BEHAVIOR ANALYSIS
- ☐ APD-ERS
- ☐ BEHAVIORAL HEALTH
- ☐ DENTAL-GENERAL
- ☐ DENTAL-MALOCCLUSION
- ☐ DME
- ☐ EPIV
- ☐ FEE-FOR-SERVICE / DISENROLLMENT
- ☐ HEARING
- ☐ HOMEHEALTH
- ☐ HOSPITAL – INPATIENT
- ☐ HOSPITAL – OUTPATIENT
- ☐ IMAGING & LABS
- ☐ COMMUNITY/OUT OF HOSPITAL BIRTH
- ☐ OCCUPATIONAL THERAPY HOSPITAL
- ☐ OCCUPATIONAL THERAPY NOT HOSPITAL
- ☐ PHYSICAL THERAPY HOSPITAL
- ☐ PHYSICAL THERAPY NOT HOSPITAL
- ☐ REHAB – INPATIENT
- ☐ REHAB – LTAC
- ☐ SPEECH HOSPITAL
- ☐ SPEECH NOT HOSPITAL
- ☐ TRANSPLANT
- ☐ VISION
- ☐ OTHER: ______________________

Length of treatment: __________ Frequency: __________ Time per session: __________

Primary diagnosis code: ______________________

Other diagnosis codes: ______________________

Dates of service From __________ To __________

II– Line item information

Line	Service code	Modifier	Description	Units	MSRP
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					

III– Dental

Tooth number: ________________________________ Quad: __________________________________

IV– Pharmacy – *Fax all pharmacy PA requests to 888-346-0178*

Drug name: ____

Strength: ____________________________________ Quantity: ______________________________

Directions: ____

V– Additional notes