Print Clear Form

DHS Oregon Department of Human Services

EDMS COVERSHEET

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

Oregon Health Authority

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.

- ☐ Provider Enrollment (PE) - 503-378-3074
- ☐ Claim Documentation - 503-378-3086
- ☐ Prior Authorization (PA)

For PA requests, also check one box below:

- ☐ Routine Processing - 503-378-5814
- ☐ Urgent Processing *(72 hours)* } 503-378-3435
- ☐ Immediate Processing *(24 hours)* }

- ☐ Hearing Documentation *(no central fax #)*
- ☐ Grievance Documentation *(no central fax #)*
- ☐ Correspondence - 503-378-3086

Justification and additional documentation is required for Urgent or Immediate processing *(summarize below)*. If your PA request does not meet Urgent or Immediate criteria, it will receive Routine processing.

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.*

DHS/OHA Prior Authorization Request Form

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):*

- ☐ APD-ERS
- ☐ BEHAVIORAL HEALTH
- ☐ DENTAL
- ☐ DME
- ☐ EPIV
- ☐ FEE-FOR-SERVICE / DISENROLLMENT
- ☐ HEARING
- ☐ HOMEHEALTH
- ☐ HOSPITAL – INPATIENT
- ☐ HOSPITAL – OUTPATIENT
- ☐ IMAGING & LABS
- ☐ OTHER: _____
- ☐ OUT-OF-HOSPITAL BIRTH
- ☐ OT HOSPITAL
- ☐ OT NOT HOSPITAL
- ☐ PT HOSPITAL
- ☐ PT NOT HOSPITAL
- ☐ REHAB – INPATIENT
- ☐ REHAB – LTAC
- ☐ SPEECH HOSPITAL
- ☐ SPEECH NOT HOSPITAL
- ☐ TRANSPLANT
- ☐ VISION

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					

III – Dental

Tooth number _____ Quad _____

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

Drug name _____

Strength _____ Quantity _____

Directions _____

V – Additional notes