IMPORTANT INSTRUCTIONS PLEASE DOWNLOAD THIS FORM

Please note we will only be accepting electronic and not handwritten forms starting 6/1/2021. For faster and more efficient processing please submit via the online portal.

We are asking Providers to use our online tools for the following requests. Please check codes online to confirm a review is required before submitting a prior authorization request. This will help ensure we are able to get to qualifying requests in a timely manner. We also encourage you to submit your Prior Authorization Request on the Portal for faster processing.

- Patient Eligibility
- Prior Authorization Code Checks
- Prior Authorizations
- Status checks, even if faxed prior (for in area providers only)

A screenshot with the date included of the information found online can be used for verification documentation in the event you need to appeal.

Check it out today at:

About Prior Authorization | Provider | LifeWise Health Plan of Oregon (lifewiseor.com)

PRE-SERVICE/ PRIOR AUTHORIZATION REVIEW REQUEST

Complete and fax to Care Management at 800-843-1114.

LifeWise

LifeWise Health Plan of Oregon

Request date:

MEMBER/PATIENT: _____ Date of birth: _____

Member ID: _____ Suffix: _____ Group #: _____

REQUESTING PROVIDER: _____

Address: _____

City/State/ZIP: _____

Phone: _____ Fax: _____

Contact person: _____

Tax ID (**required**):_____

NPI # (if available): _____

SERVICING PROVIDER: _____

Address: _____

City/State/ZIP: _____

Phone: _____ Fax: _____

Contact person: _____

Tax ID (**required**):_____

NPI # (if available): _____

REQUIRED: Complete all fields that apply for place of service.

FACILITY: _____

Address: _____

City/State/ZIP: _____

Tax ID (**required**):_____

NPI # (if available): _____

Phone: _____ Fax: _____

☐ Outpatient hospital ☐ Inpatient hospital
☐ Office ☐ Ambulatory surgical center
☐ Ongoing treatment

* For medical and psychiatric lower levels of care, use our Admission/Concurrent Review Fax Form.

Date scheduled: _____

Existing reference #: _____

Expiration date: _____

☐ **URGENT REQUEST**

PLEASE NOTE: Scheduling issues do not meet the definition of urgent.

Urgent requests must be signed and include supporting documentation from the provider's office, noting that standard timeframes for making a non-urgent determination could:

- Seriously jeopardize the life/health of the patient or the ability to regain maximum function, **or**
- Seriously jeopardize the life, health or safety of the member or others, due to the member's psychological state, **or**
- In the opinion of a provider with knowledge of the member's medical or behavioral condition, subject the patient to adverse health consequences without the requested care or treatment.

I attest that this request meets the urgent definition described above: MD signature: _____

CLINICAL INFORMATION required. Attach supporting medical records and include presenting symptoms and previous treatment.

Procedure code/CPT code:	**Modifier: (LT/RT/ NU/RR)**	**ICD diagnosis code:**

Note: Unless specifically requested elsewhere in this document, do not send a DNA or other genetic sample, or the results of any genetic typing, test, or analysis, including DNA.