PO Box 40384
Portland, OR 97240

Behavioral Health Authorization Request Form

Phone (855) 294-1665 Fax (503) 488-3674

Patient Information

Patient Name _____ DOB _____ ID # _____

Subscriber Name _____ Group # _____ Group Name _____

Provider Information

Provider Name _____ TIN # _____ NPI # _____

Ph # _____ Ext # _____ Fax # _____ Contact _____

Address/Location _____

Facility Information

Facility Name _____ TIN # _____ NPI # _____

Ph #_____ Ext # _____ Fax # _____ Contact _____

Address/Location _____

Authorization Information

ICD Code(s) _____

CPT/HCPCS Code(s) _____

Service Description _____

Date Span Requested _____ to _____ # units _____

Additional Comments