



PO Box 40384  
Portland, OR 97240

**Medical - Commercial Authorization/Referral Request Form**  
(503) 243-4496; (800) 258-2037; Fax (503) 243-5105  
**DO NOT USE FOR BEHAVIORAL HEALTH AUTHORIZATION REQUESTS**

Referral      Service Authorization      Retro Authorization

**If you require a RUSH Prior Authorization for a procedure being done within 48 hours,  
please call Moda Health at (503) 243-4496 or (800) 258-2037**

**Patient Information**

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_ ID # \_\_\_\_\_  
Subscriber Name \_\_\_\_\_ Group # \_\_\_\_\_ Group Name \_\_\_\_\_

**PCP/On-Call Doctor Information**

PCP/On Call Doctor \_\_\_\_\_ TIN # \_\_\_\_\_ NPI # \_\_\_\_\_  
Ph # \_\_\_\_\_ Ext # \_\_\_\_\_ Fax # \_\_\_\_\_ Contact \_\_\_\_\_

**Specialist Information**

Facility Name \_\_\_\_\_ TIN # \_\_\_\_\_ NPI # \_\_\_\_\_  
Ph # \_\_\_\_\_ Ext # \_\_\_\_\_ Fax # \_\_\_\_\_ Contact \_\_\_\_\_  
Address/Location \_\_\_\_\_

**Facility Information**

Facility Name \_\_\_\_\_ TIN # \_\_\_\_\_ NPI # \_\_\_\_\_  
Ph # \_\_\_\_\_ Ext # \_\_\_\_\_ Fax # \_\_\_\_\_ Contact \_\_\_\_\_  
Address/Location \_\_\_\_\_

**Authorization/Referral Information**

ICD Code(s) \_\_\_\_\_ Inpatient  
CPT/HCPCS Code(s) \_\_\_\_\_ Outpatient  
Service Description \_\_\_\_\_  
Date Span Requested \_\_\_\_\_ to \_\_\_\_\_ # OP Visits/IP Nights \_\_\_\_\_  
Scheduled Date \_\_\_\_\_

**For Medications Administered in Provider Office Only**

Requested Dose and Treatment Interval \_\_\_\_\_

**Additional Comments**