



Oregon

Theodore R. Kulongoski, Governor

Department of Human Services
Health Services

Division of Medical Assistance Programs

500 Summer Street NE, E35

Salem, OR 97301-1077

Voice - (503) 945-5772

FAX - (503) 373-7689

TTY - (503) 378-6791

**REQUEST FOR PRIOR AUTHORIZATION
FOR OUT-OF-STATE SERVICES**



This form should be completed by the attending physician who is requesting prior authorization for an out-of-state (OOS) service. Once completed, FAX to 1-503-373-7689 or mail to:

DMAP
Medical Directors' Office
Out-of-State Coordinator
500 Summer Street NE, E-49
Salem, Oregon 97301-1079

Confirm receipt with the coordinator by calling 1-503-945-5802.

Client Name: _____

DOB: _____ Medicaid ID #: _____

Out-of-State Physician _____ Phone: _____ Fax: _____

Address: _____

Hospital Name & Address: _____

Contact Person: _____

*ICD-9 Diagnosis: _____

*CPT Procedure Code(s): _____

*"Assisting People to Become Independent, Healthy and Safe"
An Equal Opportunity Employer*

Specify out-of-state service requested: _____

History of Condition and treatment previously provided: _____

Treatment alternatives to requested service: _____

*Verification of availability in Oregon: _____

*Has there been a second opinion? _____ By whom? _____

*Is this treatment available in Oregon? _____ Where? _____

*Is this treatment investigational or experimental? _____

What is the prognosis and to what extent is this treatment likely to improve the patient's condition? _____

What are the anticipated medical consequences if the treatment is not provided?

Physician signature: _____ Date: _____

Name: _____

Address: _____

Phone: _____ Fax: _____