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INSTRUCTIONS FOR PRE-AUTHORIZATION FORM

Failure to include any required information will delay review.
For retrospective reviews, please contact the appropriate claims department.

Complete the top portion of the form with your name, phone and fax numbers, and what office you are from. Include patient's name, date of birth, and Kaiser Medical Record Number (MRN) from the patient's insurance card. Note: each member, including children and dependents, has his/her own unique Medical Record Number.

Recent supporting history and physical (H&P), clinical notes, and physician's order are required before review can begin. Failure to provide these documents in a legible format (i.e. dictated/typed) may delay review.

Diagnosis Codes and **Procedure Codes** (CPT or HCPCS) are required.

Requesting Provider (Physician) refers to the provider who is ordering the procedure or service and is following patient's care for this condition. Physician's specialty, mailing address, and phone number are required. Please include the best phone number for contacting the physician.

Place of Service/Servicing Provider refers to the facility or provider who is actually performing the procedure or providing the service (e.g. hospital/facility). Mailing address, phone number, and Tax ID number are required.

Please fax completed form with supporting documentation to 877-800-5456. Pre-authorization requests must be submitted by a healthcare provider. If you have any questions about the pre-authorization request form, the pre-authorization process, or what services require pre-authorization, please call us at the phone number below.

Kaiser Permanente NW Regional Referral Center: 503-813-4560 or 1-866-813-2437

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NORTHWEST REGIONAL REFERRAL CENTER – PRE-AUTHORIZATION REQUEST FORM

COMPLETE ALL INFORMATION ON THE FORM. INCOMPLETE SUBMISSIONS MAY BE RETURNED UNPROCESSED. Please direct any questions regarding this form to the Regional Referral Center to which you submit your request for external service request. This form is not intended to replace payer specific prior authorization procedures, policies and documentation requirements.

ATTENTION: To avoid delays, please complete form in its entirety and fax all information at least 2 business days prior to scheduled procedure or service.

For retrospective reviews, please contact the appropriate claims department.

MEMBER INFORMATION	
Patient Name:	☐ **Male** ☐ **Female** **DOB:**
KP MRN:	**Phone:**

REQUESTING PROVIDER/PHYSICIAN	
Requesting Clinician:	**MD** ☐ **DO** ☐ **Other** ☐
NPI#:	**Contact Person:**
Phone:	**Fax:**
Company Name: **Address:** **Tax ID #:**	

NOTE: Include any clinical information to support medical necessity (*Required).*

PLACE OF SERVICE/SERVICING PROVIDER	
NAME OF PLACE OF SERVICE:	
NAME OF SERVICING PROVIDER:	**MD** ☐ **DO** ☐ **Other** ☐
Mailing Address:	
Phone:	**Fax:**
Tax ID #:	

SERVICE REQUESTED	
Care Requested (i.e. Consult, DX study, Procedure):	
Inpatient ☐ **Outpatient** ☐	
Number of Visits Requested:	**Date of Service (if known):**
Specialty / Department:	
Diagnosis Code(s):	
Diagnosis Description:	
Procedure CPT/HCPCS Code(s):	
Procedure CPT/HCPCS Description:	
Additional Information:	

SUBMIT FORM TO: *Kaiser Permanente – Regional Referral Center*

Fax: 877-800-5456

500 NE Multnomah, Suite 100, Portland, OR 97232-2099

Questions related to this form should be directed to: **Phone:** 503-813-4560 or 1-866-813-2437