Comagine Health

Oregon Behavioral Health Support Program CH-007

Oregon Prior Authorization Request

Please enter the consumer's name as it appears in the Medicaid Management Information System (MMIS)



650 NE Holladay St, Suite 1700
Portland, Oregon
Phone: 888-416-3184
Fax: 877-575-8309

Comagine Health
www.comagine.org/obhsp

Oregon Behavioral Health Support Program
Oregon Prior Authorization Request
Form CH-007: PA-Rehab - Psychosocial Rehabilitation Services (PRS)

Please send completed requests to Comagine Health via one of the following methods:
Fax: 877-575-8309 Secure email: ORBHSupport@comagine.org Mail: Comagine Health – OBHSP
650 NE Holladay St., Suite 1700
Portland, OR 97232

Please complete this form to request prior authorization of Psychosocial Rehabilitation Services (outpatient rehabilitation). Complete all fields and **provide clinical documentation sufficient to determine medical necessity**. Ensure the referring provider and rendering provider information is complete.
To request authorization for residential services, please use the Form CH-006 (Plan of Care Authorization).

Request Information		
Last name:	First name:	MI:
Date of birth:	Medicaid ID (prime number):	Social Security number:
Is individual/member eligible for Home- and Community-Based Services 1915(i) benefits? ☐ Yes ☐ No		Diagnosis (DSM 5/ICD 10):
Behavioral health program name:		Phone:
Referring provider number:		Rendering provider number:

Services Requested

Description	Procedure code	Modifiers	Requested start date	Requested end date	Number of units or dollar amount

☐ *Indicates more services requested on page 2 of this form.*

Form CH-007: PA-Rehab
August 2020

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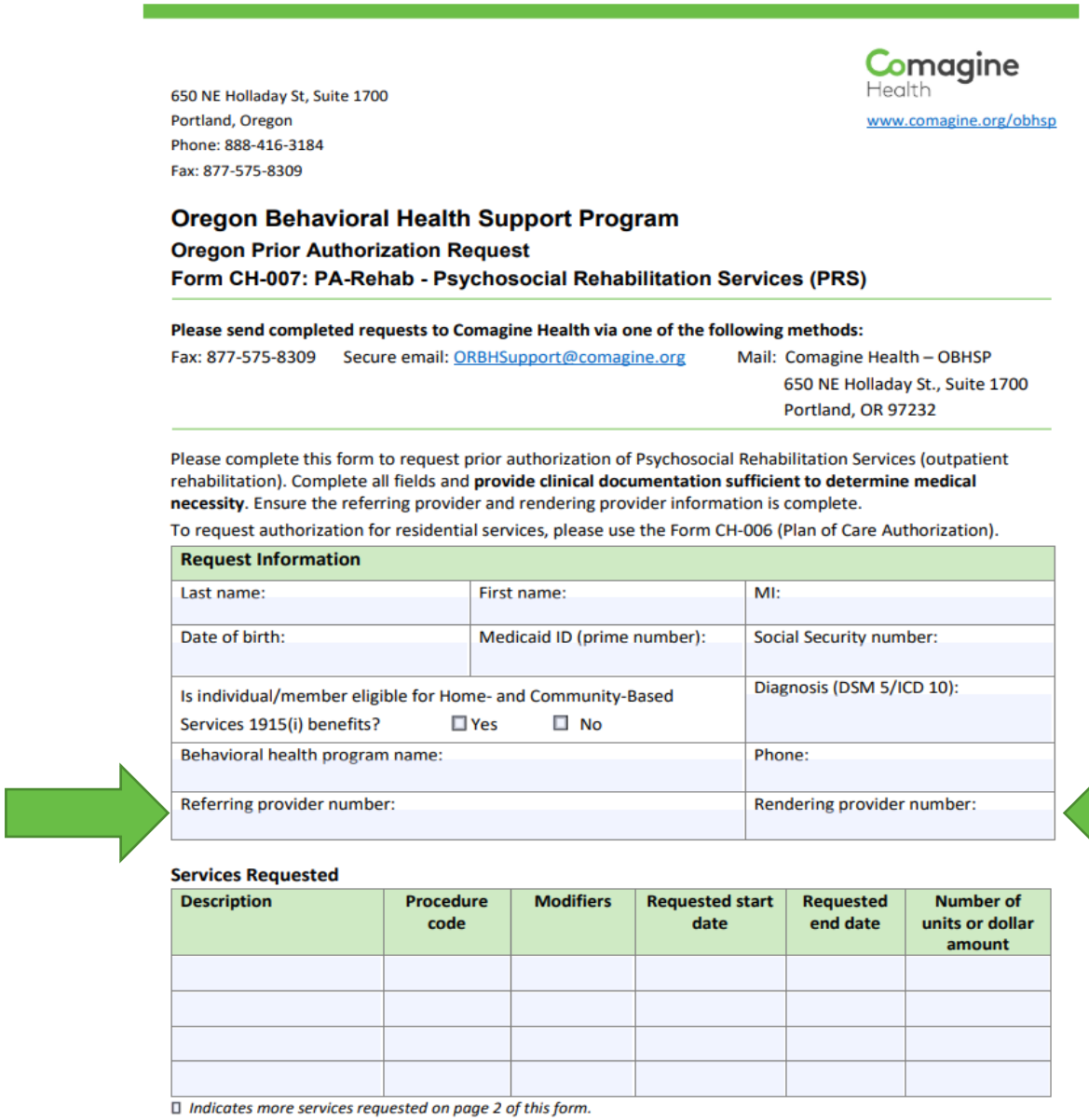


Required Documentation:

- CH007
- Mental Health Assessment (dated within one year of submission)
- Treatment/Service Plan (dated within one year of submission)
- Progress notes can also be included to support services requested
- All documents should be uploaded to MMIS with the prior authorization submission

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Referring Provider: Entity requesting services (i.e. Community Mental Health Provider, County etc.)



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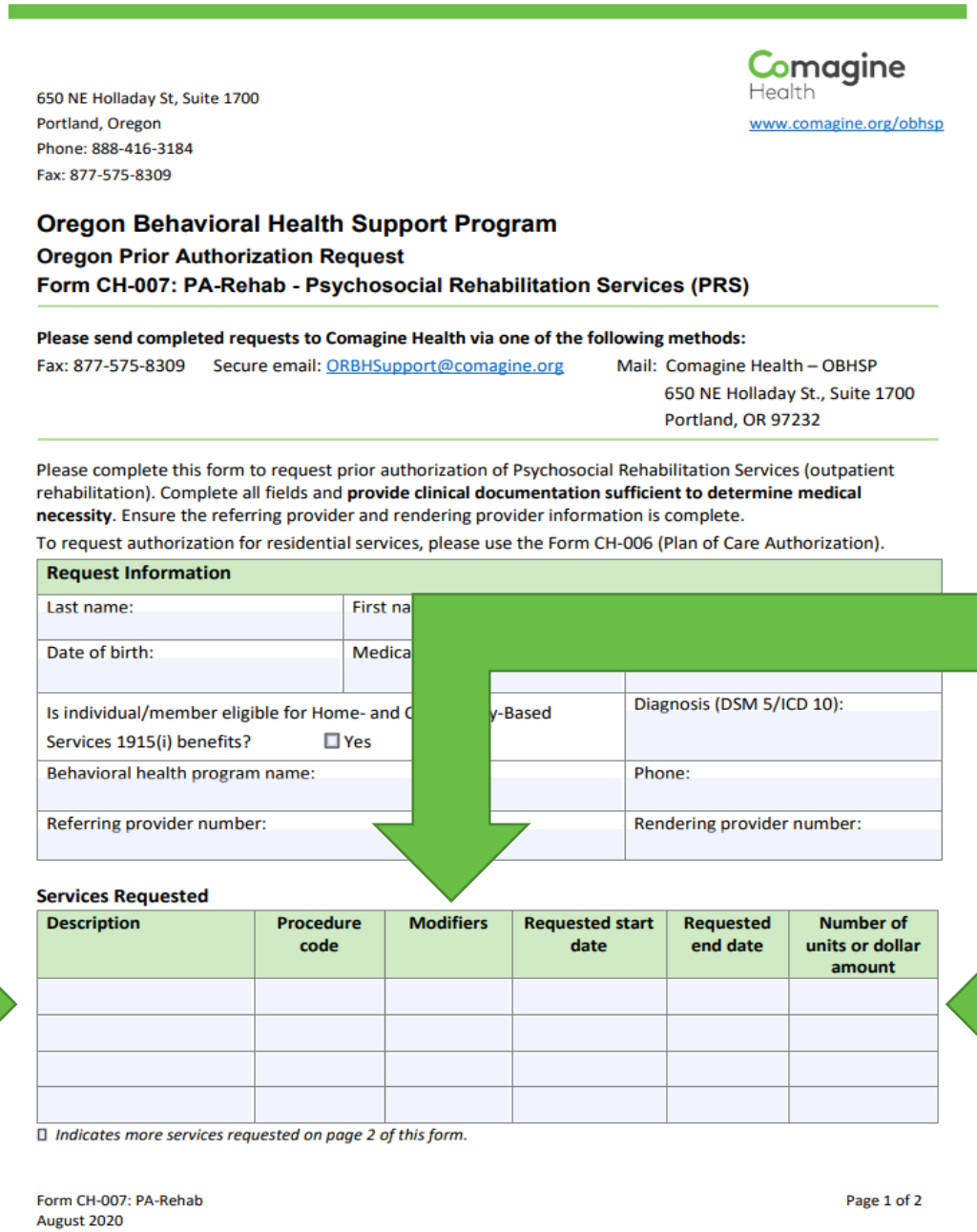
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Rendering Provider: Provider delivering the service

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Request Information

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Date of birth:	Medica
Is individual/member eligible for Home- and C Services 1915(i) benefits? ☐ Yes	y-Based Diagnosis (DSM 5/ICD 10):
Behavioral health program name:	Phone:
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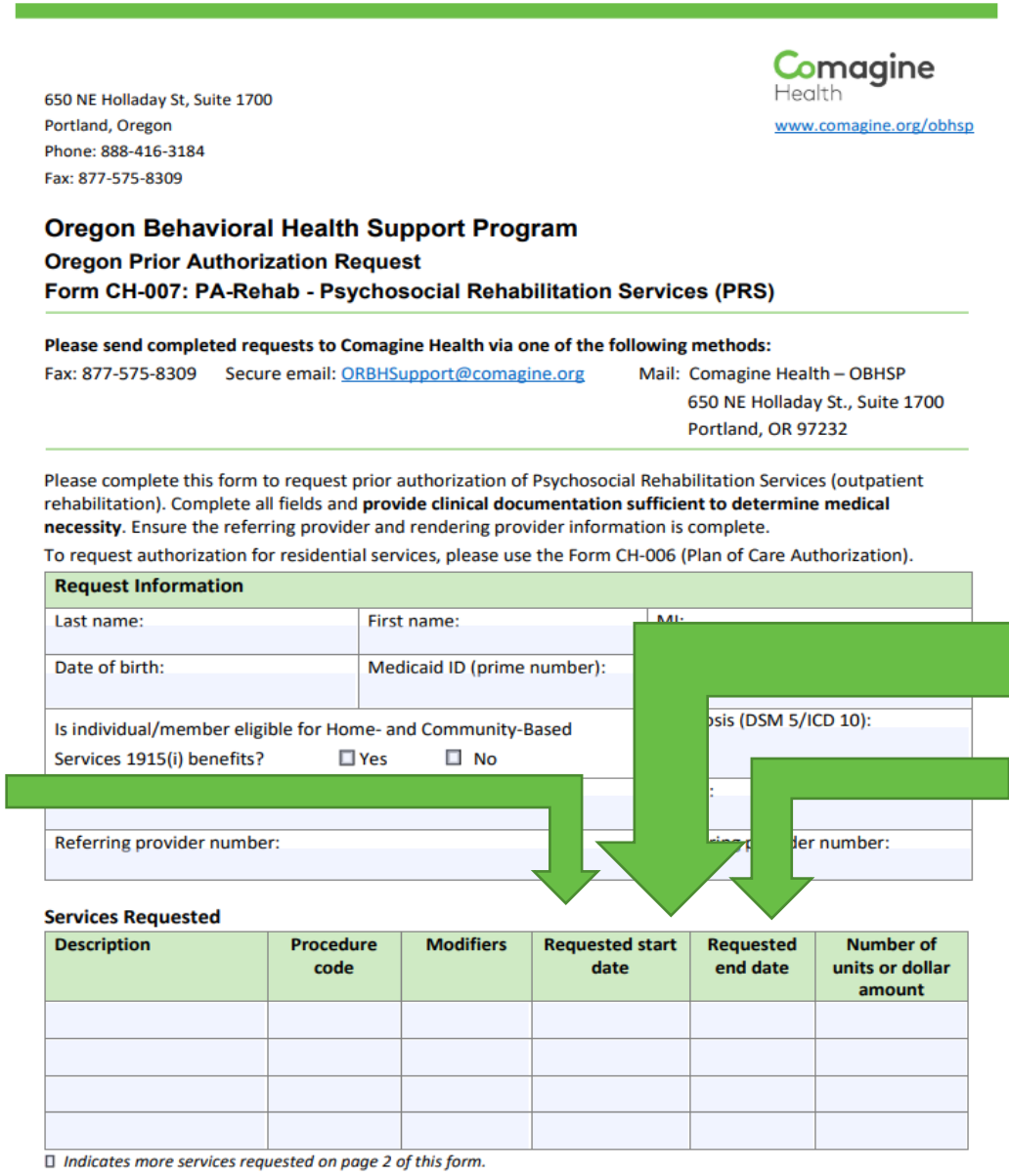
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The IQA (Comagine Health) only reviews prior authorizations requiring the HK modifier.

BH Fee Schedule description

Please review the most current BH Fee Schedule for applicable MH Outpatient Services Fee Schedule

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Start Date:
No sooner than the date of admission or one day after the last Prior Authorization request

Maximum Requested Date Range:
- SRTF-90 days
- Enhanced Care Services-180 days
- AFH/RTH/RTF-364 days
- In-Home Services-364 days
- Crisis Respite-30 days

End Date:
This should be no longer than 89 days from start date for SRTF prior authorization requests , and 364 days for all other prior authorization requests.

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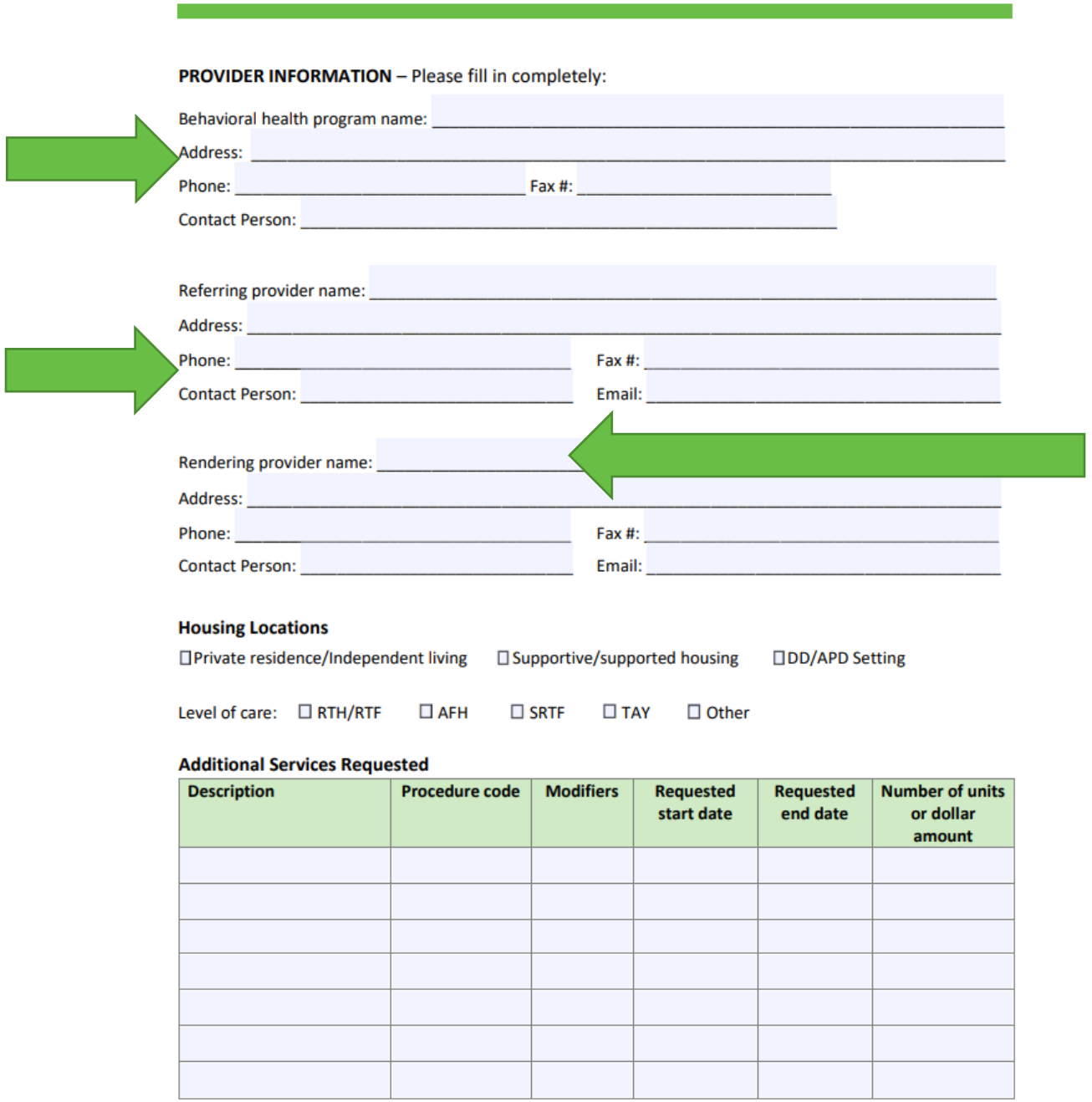
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Please include number of units requested from MMIS prior authorization entry

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Behavioral health program name: Location where services are provided

Referring provider name: Entity requesting services (i.e. Community Mental Health Provider, County etc.)



PROVIDER INFORMATION – Please fill in completely:

Behavioral health program name: _____

Address: _____

Phone: _____ Fax #: _____

Contact Person: _____

Referring provider name: _____

Address: _____

Phone: _____ Fax #: _____

Contact Person: _____ Email: _____

Rendering provider name: _____

Address: _____

Phone: _____ Fax #: _____

Contact Person: _____ Email: _____

Housing Locations

☐ Private residence/Independent living ☐ Supportive/supported housing ☐ DD/APD Setting

Level of care: ☐ RTH/RTF ☐ AFH ☐ SRTF ☐ TAY ☐ Other

Additional Services Requested

Description	Procedure code	Modifiers	Requested start date	Requested end date	Number of units or dollar amount

Contact information is required for all areas, including email addresses

Rendering provider name: Provider delivering the service

Comagine Health

PROVIDER INFORMATION – Please fill in completely:

Behavioral health program name: _____

Address: _____

Phone: _____ Fax #: _____

Contact Person: _____

Referring provider name: _____

Address: _____

Phone: _____ Fax #: _____

Contact Person: _____ Email: _____

Rendering provider name: _____

Address: _____

Phone: _____ Fax #: _____

Contact Person: _____ Email: _____

Housing Locations

☐ Private residence/Independent living ☐ Supportive/supported housing ☐ DD/APD Setting

Level of care: ☐ RTH/RTF ☐ AFH ☐ SRTF ☐ TAY ☐ Other

Additional Services Requested

Description	Procedure code	Modifiers	Requested start date	Requested end date	Number of units or dollar amount

Please check "other" for supported housing and independent living

Check the consumer's current housing location. Use Supportive/supported housing for all residential locations (RTH, RTF, SRTF)

Developmental Disability or Aging and People with Disabilities location

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