# Out of Network (OON) Provider Behavioral Health Authorization Form

eocco
EASTERN OREGON COORDINATED CARE ORGANIZATION

**Send Authorization Requests via:** Fax: 541-296-1036 or SECURE Email: um@gobhi.org

If you have behavioral health authorization form questions, please call 1-541-298-2101.

**Documentation Required** *Check to confirm that each of these required items is included in your request:*

☐ **Assessment** ☐ **Service plan** ☐ **Progress notes** ☐ **MARs** ☐ **Discharge summary**

Date of Request: _____

| Member Name | | Date of birth (mm/dd/yyyy) |
|---|---|---|
| OHP number | | Member Phone Number |
| Member Address | | |
| Start Date | End Date | Current Diagnosis Code |

| CPT code(s): | Units/Days: | CPT code(s): | Units/Days: |
|---|---|---|---|
| CPT code(s): | Units/Days: | CPT code(s): | Units/Days: |
| CPT code(s): | Units/Days: | CPT code(s): | Units/Days: |

| |
|---|
| Has the member previously been seen by their local Community Mental Health Provider (CMHP)? Yes ☐ No ☐ |
| Does the member want to opt out of calls by the CM Team to the local CMHP for care coordination? Yes ☐ No ☐ |
| Is there an in-network provider able to deliver the same services? Yes ☐ No ☐ |
| Why does the member need to go out of network: |

## Provider Information

Accurate information is needed for processing claims and credentialing purposes. The Rendering Practitioner (individual/licensed clinician) and Billing Facility (facility/clinic that is billing for the services) must be registered with the State of Oregon at the time of service in order to receive payment.

| **Billing Facility** |
|---|
| Needed For All OON Auth Requests |
| Name |
| Tel # |
| Fax # |
| TIN # |
| OR Medicaid Provider # |
| NPI # |

| Billing Facility | | | |
|---|---|---|---|
| Needed For All OON Auth Requests | | | |
| Billing Address | City | State | Zip |
| Contact Name | | | |
| Contact Email | | | |
| Contact Phone | | | |
| Preferred method of contact: ☐ Phone ☐ Email ☐ Fax | | | |

| Rendering Provider |
|---|
| Needed For Out Patient OON Auth Requests Only |
| Name (As spelled on professional license) |
| Professional License/Title |
| License # and Issuing State |
| TIN # |
| OR Medicaid Provider # |
| NPI # |
| Physical Address |

## Signature

Provider/Facility Authorized Signature

Date

## Ready to submit?

**Eastern Oregon CCO Claims**
P.O. Box 40384, Portland, OR 97240
**Questions?** Call 888-788-9821.

**eocco.com**