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

Plan of Care Request for Behavioral Health Residential or Personal Care Services

Form CH-006: PA-BH-Res-PCS

This form includes information required for a plan of care for adult foster homes or residential personal care/habilitation services.

For an initial referral, this form may accompany Comagine Health Referral Form (CH-001). Comagine Health is responsible for notifying providers of annual redetermination and service authorization end dates. Comagine Health will send/fax the POC Request form CH-006 to providers, no earlier than 60 days and no later than 30 days ahead of the service authorization end date. Providers will have **10 business days** from the date the form is sent/faxed to submit the required documentation listed on this form.

Please submit PA requests via MMIS.

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

Use this form to request a plan of care for adult foster care or residential personal care/habilitation services. **Include a copy** of the following:

- ☐ Mental/Behavioral Health Assessment signed by QMHP within one year of service start date for current authorization
- ☐ Residential care plan (if not included in the ISSP) must be within one year of authorization start date
- ☐ Additional supporting documentation reflected in Referral-form-CH-001

Also, please provide a **fax number** that Comagine can send correspondence to: _____

Member Information

Last Name: _____ Social Security Number: _____

First Name: _____

Date of Birth: _____ Primary ICD-10 Diagnosis Code: _____

Medicaid ID (prime number): _____

Request Information

This request is for (select one): ☐ Initial Request ☐ Reauthorization

Behavioral Health Program Name: _____

Date of Admission (MM/DD/YYYY): _____

Referring Provider MCD Number: _____

Rendering Provider MCD Number: _____

Level of Care (select one): ☐ AFH ☐ RTH ☐ RTF ☐ SRTF

County of Responsibility: _____

Rate: $ per _____ (select one): ☐ Month ☐ Week ☐ Day

Procedure Code: _____

Modifiers: ☐ HK ☐ HE ☐ TG ☐ HW

Number of Units Requested (over full duration): _____

Dates of Service:

From (MM/DD/YYYY): _____ To (MM/DD/YYYY): _____

LSI Composite Score: Add-On: _____

Please sign on next page.

SIGNATURES

By signing below, the Community Mental Health Program (CMHP) and Mental Health Organization (MHO) or Coordinated Care Organization (CCO) verify that they have reviewed the above services and recommend them for this member.

_____	_____	_____
CMHP representative signature	Name and Title	Date
_____	_____	_____
MCO/CCO representative signature	Name and Title	Date

Save as Print Clear form