

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



www.comagine.org/obhsp

Oregon Behavioral Health Support Program

Plan of Care Authorization

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, please complete and submit this form. 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 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, if applicable:

- Mental/Behavioral Health Assessment signed by Qualified Mental Health Professional (QMHP) within one year of service start date for current authorization
- Residential care plan must be within one year of authorization start date
- Conditional Release/Community Evaluation for individuals involved with Psychiatric Security Review Board (PSRB)
- Additional supporting documentation reflected below

Please provide a **fax number** that Comagine can send correspondence to: _____

Please provide an **email address** that Comagine can contact you at: _____

Individual/Member Information

Last Name: _____

First Name: _____

Date of Birth: _____

Primary ICD-10 Diagnosis Code: _____

Medicaid ID (prime number): _____

Legal Guardian

Legal Guardian Name: _____

Relationship to Individual: _____

Legal Guardian Address: _____

Legal Guardian Phone: _____

Legal Guardian Email Address: _____

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: _____

Referring Provider Phone Number: _____

Rendering Provider MCD Number: _____

Rendering Provider Phone 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): _____

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