allcare advantage

AllCare Advantage Prior Authorization Request

This form allows you to submit for an authorization request to get prior approval for a medical service or drug you think is covered. Some services will require your Provider to write you an order or Prescription. Please fill out the below and mail, fax or hand deliver this form, along with any pertinent medical documentation to us.

Date: _____ Member ID: _____ Member DOB: _____

Member Name: _____

*Requested by: _____Relation to Member:_____

*If requested by someone other than member, must include POA or AOR form. AORs are valid one year.

Representative Name: _____

Mailing Address:_____

☐ **Expedited –please provide reason:** _____

☐ **Standard**

Service/drug requested: _____

Referring/Ordering Provider: _____

Location of service/Pharmacy: _____

If scheduled, date of service: _____

Fax to: 541-471-4128

Mail to: AllCare Health, Attn: AllCare Advantage
1701 NE 7th Street
Grants Pass, OR 97526

AllCare Health Plan, Inc. appreciates your time in submitting your request. You will receive a written decision within the applicable AllCare Advantage guidelines. If you have questions or would like to check the status of your request, please contact the AllCare Health Member Services department at (541) 471-4106, Toll-free (888) 460-0185, TTY 711. Calls are answered seven (7) days a week, 8 a.m. to 8 p.m., Pacific Time. Office hours are Monday – Friday 8 a.m. to 5 p.m., Pacific Time.
Thank you, AllCare Health Utilization Management

1701 NE 7th St.
Grants Pass, OR 97526
Phone (541) 471-4106
Fax (541) 471-4128
Toll free (888) 460-0185
TTY (800) 735-2900
AllCareHealth.com