

Oxygen And Respiratory Authorization Request

| PROVIDER INFORMATION | | |
|--|----------------|-------------------------------------|
| PROVIDER NAME | | PROVIDER NPI |
| TELEPHONE NUMBER | FAX NUMBER | |
| CLIENT INFORMATION | | |
| CLIENT NAME | | PROVIDERONE CLIENT ID |
| SERVICE REQUEST INFORMATION | | |
| PROCEDURE CODE | | DATE |
| Description of service/item being requested: | | |
| What program criteria requires you to submit this request? | | |
| UNITS REQUESTED | LENGTH OF NEED | UNITS USED IN THE LAST THREE MONTHS |
| PLACE OF SERVICES | | |
| MEDICAL INFORMATION | | |
| Related respiratory or medical diagnosis: | Dx | ICD |
| | Dx | ICD |
| What is the medical justification for this request? | | |
| How will approval of this request functionally benefit the client? | | |
| Is there a less costly alternative? What is it? Why won't it work for this client? | | |

A copy of the prescription must be attached to this request.

Fax: **1-866-668-1214**

Or mail to: Medical Request Coordinator

PO Box 45535

Olympia, WA 98504-5535

A typed and completed General Authorization for Information form, DSHS 13-835, must be attached to your request in order to be processed by the Department.