Health Share Treatment Authorization Request Prior Authorization (HSTAR_PA) Form

Member Information		
First Name:	MI:	Last Name:
Date of Birth:	Gender:	
Language(s) Spoken:	Contact Phone:	
Street Address:		
City:	State:	Zip:

Insurance Eligibility Information
Member Medicaid ID:
Member's Health Share Behavioral Health Plan *(please select one)*: ☐ Clackamas County ☐ Multnomah County ☐ Washington County
To verify member eligibility please look in CIM, or contact Health Share Customer Service at 503-416-8090 or 1-866-519-3845

Other Primary Insurance Information		
Check to indicate all insurance coverage. Complete Primary Insurance Plan Information when applicable. ☐ Medicare ☐ Other Insurance ☐ N/A - Member has no insurance other than Medicaid		
Carrier:	Group/Policy Number:	Effective Date:

Referent/Requestor Information	
Name:	Agency/Role:
Phone:	Fax:
Email:	

Provider Requested *(if different than Referent)*	
Agency:	Contact Name:
Phone:	Fax:
Email:	

Authorization Request *(Identify only one initial OR one concurrent request type)*

This is an initial request for	This is a concurrent request for:
☐ An assessment authorization ☐ An initial Treatment authorization (SCA providers with continuity of care only) ***Complete Parts A & C***	☐ Reauthorization (a new authorization period) ☐ Additional sessions in current authorization period ☐ An initial Treatment authorization (after authorized assessment session) ***Complete Parts B & C***

health share PATHWAYS

Part A: Initial Request *(Request must be submitted prior to the delivery of services.)* *Use to request an authorization for an initial assessment, or an initial on-going treatment authorization*	
Requested Start Date:	Projected End Date:
Briefly describe the clinical reason for the request (do not duplicate the clinical documentation being submitted):	
ICD10 Diagnosis:	
Part B: Concurrent Request (*Request must be submitted prior to the delivery of services.)* *Use to request Reauthorization, or to request additional sessions in a currently authorized treatment period*	
Current Treatment Episode Information	
Current Authorization Number:	
Effective Date:	End Date:
First date of service under current authorization:	Number of sessions to date:
Assigned LOC:	ICD10 Diagnosis:
Treatment Services Being Requested	
Requested Start Date:	Projected End Date:
Briefly describe the clinical reason(s) for additional sessions, or a reauthorization, and what progress the member needs to make in order to reach their treatment goals:	

Submit this form, Part C, and required clinical documentation (see instructions) to member's assigned Behavioral Health Plan Partner:

- Clackamas County Behavioral Health – via Fax: (503)742-5355
- Multnomah County Behavioral Health - via Email: asoc.team@multco.us or via Fax: (503-988-9383)
- Washington County Behavioral Health – via Fax: (503)846-3522

For questions regarding the completion of the HSTAR form, please contact the member's assigned Behavioral Health Plan Partner:

- Clackamas County: 503-742-5348
- Multnomah County: 503-988-5887
- Washington County: 503-291-1155