Effective: January 1, 2019

Authorization Requirements

Health Net Health Plan of Oregon, Inc. and Health Net Life Insurance Company (Health Net)

- Medicare Advantage PPO (MA PPO)
- Medicare Advantage HMO (MA HMO)

All services are subject to benefit plan coverage, member eligibility and medical necessity, irrespective of whether prior authorization is required. When faxing a request, please attach pertinent medical records, treatment plans, and test results to support the medical appropriateness of the request. Health Net reserves the right to review utilization patterns retrospectively and to address adverse trends with providers.

Referrals to participating specialists – Providers are not required to obtain prior authorization from Health Net for referrals to Health Net participating specialists. For MA PPO plans, prior authorization may be required for out-of-network coverage. Unless noted differently, all services listed below require prior authorization from Health Net. Refer to Prior Authorization Contacts for submission information. Providers can refer to the member's Health Net identification (ID) card to confirm product type.

This prior authorization list contains some services that require prior authorization only and ***is not intended to be a comprehensive list of covered services.*** The member's plan contract or Evidence of Coverage (EOC) provides a complete list of covered services. Plan contracts and EOCs are available to members on the member portal at www.healthnet.com or in hard copy on request. Providers may obtain a copy of a member's plan contract or EOC by requesting it from the Health Net Customer Contact Center.

To verify if a service requires an authorization, use the Medicare Pre-Authorization look up tool at: https://or.healthnetadvantage.com/for-providers/medicare-pre-auth.html

Submit requests to Health Net via the **Provider Portal** at: provider.healthnetoregon.com

The Health Net Prior Authorization form must be completed in its entirety and include sufficient clinical information or notes to support medical necessity for services that are requested.

Type of Service	Authorization Requirement
Elective procedures or scheduled admissions	Verify authorization requirements using the Pre-auth tool
Observation stays	Notification within 1 business day of admission Medicare: Authorization required after 48 hours
Urgent or emergent services or admissions	Notification within 1 business day. Admission request required within 2 business days following admission.
Skilled nursing, inpatient rehab, long-term acute care	Authorization required
Inpatient Behavioral health services	Authorization required
Outpatient Behavioral health services	Verify authorization requirements using the Pre-auth tool
Outpatient services	Verify authorization requirements using the Pre-auth tool
Services rendered in the home	Authorization required
Hospice Care	Authorization required
High- Tech imaging	Verify authorization requirements using the Pre-Auth tool – Managed by NIA, request authorizations at: www.Radmd.com
All out-of-network services	Authorization required

Please refer to the Health Net Pre-Authorization Tool accessible via the Provider Resources page at:

https://or.healthnetadvantage.com/for-providers/medicare-pre-auth.html