



PAYMENT AUTHORIZATION REQUEST FORM

Indigent Youth Substance Use Disorder Residential Treatment

AMH use only

PA number:

Approved:

Denied:

Provider Information

Requesting provider name:

AMH Contract Number:

Contact name:

Phone number:

Email Address:

Client Information

Client MOTS ID:

Last Name:

First name:

MI:

DOB (MM/DD/YYYY):

Individual is indigent, they have no insurance coverage, private or public

(Medicaid/Medicare) that covers youth SUDs residential treatment. Yes: No:

Service Information

Estimated length of treatment:

Explain Primary diagnosis:

Primary ICD-9:

Other pertinent ICD-9 diagnosis codes:

ASAM Level of care:

*Submit payment form and attach appropriate clinical justification for services requested;
assessment and treatment plan in a secure email to: amhcontract.administrator@state.or.us*