***Attestation for Prior Authorization Determinations***

***for Substance Use Disorder Services***

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| --- | --- | --- | --- |
| Contract Year: 2024 | | | |
| Coordinated Care Organization (Contractor) Name: | |  | |
| Medicaid Contract Number (6 digits only): |  | |

The Coordinated Care Organization (CCO) named above is required to submit this Attestation relating to Prior Authorization (PA) determinations for Substance Use Disorder (SUD) treatment services and supports pursuant to Exhibit M, Section 7, Paragraph j in the contract between the Oregon Health Authority (OHA) and the CCO.

By signing this Attestation, I, the undersigned, hereby attest to the following:

1. I have authority, in accordance with Section 4.1.1 in the General Provisions of the CCO contract, to make this Attestation on behalf of the CCO named above; and
2. To the best of my knowledge, CCO staff responsible for making PA determinations for SUD treatment services and supports in Contract Year 2024 as well as staff of any Subcontractor(s) to which the CCO may have Delegated such responsibility have working knowledge of the American Society of Addiction Medicine (ASAM) Criteria, as required by the OHP SUD 1115 Demonstration waiver (and as “the ASAM Criteria” is defined in OAR 309-019-0105).

**CONTRACTOR**

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|  | |  |  |  |  |
| Name | |  | Signature |  | Date |
| *Authority of above signer:* | Chief Executive Officer, | | | | |
| Chief Financial Officer, or | | | | |
| Employee with delegated authority as designated by the “Delegation Authorization and Signature Form” | | | | |