



2018 Therapy Form

- Please submit all 2017 therapy requests via Connect
 - Effective 1/1/2018, this form will no longer be active and all therapy requests will need to be submitted via Connect
- Fax Form and Chart Notes to: 503-416-3724 or 1-888-272-9315

**Verify service requires an authorization before completing the authorization request form.
The information is posted on the CareOregon Website @ www.careoregon.org**

1. PERSON COMPLETING THE FORM:

Date: ___/___/___ Name: _____ working @: PCP Office Spec/Ancillary Office

Telephone #: _____ Fax #: _____

2. MEMBER NAME: _____/_____/_____
Last/First/MI

DOB: ___/___/___ Subscriber ID#: _____

3. PROVIDER INFORMATION:

Ordering Provider Name: _____ Clinic Name: _____ Fax #: _____

Rendering Provider Name: _____ Clinic Name: _____ Fax #: _____

4. DIAGNOSIS (Dx) AND COMORBID CONDITIONS INFORMATION:

Primary Dx code: _____ Secondary Dx code (if applicable): _____

Does the member have a comorbid medical condition that is (1) under the best possible management, but (2) it is not controlled, and (3) providing this service will significantly improve the condition? Yes no

If yes, what is the co-morbid condition(s)? Dx code: _____ Narrative _____

Please include relevant chart notes with this authorization request!

Outpatient Therapies - Please provide CPT Codes along with the # of visits for each therapy code:

PT – OT – ST: No Authorization required for evaluations with an ATL diagnosis which pairs with CPT code

PT - CPT Code: _____ # _____ CPT Code: _____ # _____ CPT Code: _____ # _____ CPT Code: _____ # _____

OT - CPT Code: _____ # _____ CPT Code: _____ # _____ CPT Code: _____ # _____ CPT Code: _____ # _____

ST - CPT Code: _____ # _____ CPT Code: _____ # _____ CPT Code: _____ # _____ CPT Code: _____ # _____

Treatment authorization requests must include therapy evaluation results & all other relevant clinical information