



OFFICE/CLINIC AUTHORIZATION FORM
 (Specialist, Therapist, Ancillary Providers)
 CareOregon Advantage (Plus/Star) and OHP (Plus/Std) Members
 Revised **January 15, 2011**
 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/Anc Office

Telephone #: _____ Fax #: _____

2. MEMBER NAME: _____/_____/_____

Last First MI

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

OHP Plus: OHP Standard: Advantage Plus: Advantage Star:

3. PROVIDER INFORMATION:

Ordering Provider Name: _____

Clinic Name: _____ Fax #: _____

Rendering Provider Name: _____

Clinic Name: _____ Fax #: _____

4. DIAGNOSIS AND COMORBID CONDITIONS INFORMATION:

Primary ICD-9 code: _____ Secondary ICD-9 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)? ICD9 _____ Narrative _____

*And, please **include relevant chart notes** with this authorization request!*

5. SERVICES REQUESTED:

Specialist office visits: Diagnostic consult: **OR** Office visits: _____ # of visits

If office/ancillary procedures: CPT code: _____ CPT code: _____ CPT code: _____

Bariatric Center evaluations: _____ # of visits **(the following information is needed to process request)**

Mbr weight: _____ lbs as recorded on (date) ___/___/___, Mbr height: _____

BMI: _____ Mbr age: _____ yrs. Does mbr have Type 2 diabetes? yes no

CPT code: _____ CPT code: _____ CPT code: _____ CPT code: _____

Outpatient Therapies: Eval: P.T. O.T. S.T. Reason for eval: _____

Treatment: #PT _____; CPT Code: _____; _____

#OT _____; CPT Code: _____; _____

#ST _____; CPT Code: _____; _____

*Treatment auth requests **must** include therapy evaluation results & all other relevant clinical information.*