

CareOregon Advantage/OHMS Prior Authorization Form (referral to a provider)



Today's date _____

Member's name _____
Last First MI

Member's DMAP ID# _____ DOB _____

Primary ICD-9 code _____ Secondary ICD-9 code (if applicable) _____

Print name of person completing this form _____

Requesting Clinic/Provider _____

Clinic phone _____ Clinic fax _____

STEP 1

Verify member's CareOregon Advantage eligibility on QNXT View

www.careoregon.org/provider/qnxt.html

Service(s) requested _____

Number of visits requested _____

STEP 2

Reason for prior authorization (check **one**)

- Benefit exception. Fax chart notes to justify exception request.
- Benefit requires prior authorization.
- Non-par provider. Print on this form or fax reason why member should see out-of-network provider.

Referral to:

Provider/Clinic Name _____

Address _____

Provider's phone _____ Fax _____

Please fax this completed form to 541-956-5460.

*Please note that CMS guidelines allow up to 14 calendar days to approve or deny this request. If your request is urgent, please print a note on this form to alert us to your processing needs. Thank you.