

Retro Facility Authorization Form

(OHP and Medicare) Revised June 15, 2017

Fax Form and Chart Notes to: 503-416-3713 or 888-272-9315

Verify service requires an authorization before completing the authorization request form.



CareOregon®

The information is posted on the CareOregon website: careoregon.org

Person Completing the Form

Name: _____ Working at PCP office Working at Specialist Office

Date: _____ Phone# _____ Fax#: _____

Member Name

Last Name: _____ First Name: _____ MI: _____

DOB: _____ Subscriber ID: _____

PCP Name: _____ Clinic Name: _____

Provider Names

Specialist Name: _____ Fax#: _____

Clinic Name: _____

Facility Name: _____

Diagnosis (Dx) / Procedure Information

Primary DX: _____ DX Code: _____

Primary Proc: _____ CPT/CDT-4: _____

Secondary DX: _____ DX Code: _____

Secondary Proc: _____ CPT/CDT-4: _____

Additional Proc: CPT/CDT-4: _____ CPT/CDT-4: _____ CPT/CDT-4: _____

Comorbid Conditions

(1) 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 comorbid condition(s)? Dx Code: _____ Narrative: _____

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

Level of Care Requested

Ancillary Dept. Clinic/Office Procedure Room Ambulatory Surgery Center (ASC)

Hospital Day Patient/Surgery Hospital Inpatient

Anticipated or Actual Admit Date: _____ Anticipated# of Days: _____

Reason for the Retro Request

Admin Delay - PA process Eligibility Determination Natural Disaster

Third Party Litigation Other