CareOregon
315 SW Fifth Avenue, Suite 900
Portland, Oregon 97204
503-416-4100 or 800-224-4840
877-416-4161 (TTY/TDD)
www.careoregon.org

FACILITY AUTHORIZATION FORM

CareOregon Advantage (Plus/Star) and OHP (Plus/Std) Members
Revised January 2009

Fax Form and Chart Notes to: 503-416-3713 or 1-888-272-9315

NOTE: Medicare and OHP guidelines allow up to 14 calendar days to process authorization requests. However, authorization requests submitted with complete information and chart notes are typically processed within 2-5 working days. If the member's medical condition is urgent, please mark URGENT on this form to alert us.

Name of Person Completing Form: _____Date: ____/____/_____

Phone #: _____ Fax #: _____ From: PCP Office ☐ Spec Office ☐

Member Name: _____/ _____/_____
Last First MI

DOB: ____/____/_____ DMAP ID#: _____ SS#: _____
OHP Plus: ☐ OHP Standard: ☐ Advantage Plus: ☐ Advantage Star: ☐

Primary Dx: _____ ICD-9: _____

Secondary Dx: _____ ICD-9: _____

Primary Proc:_____ CPT:_____

Secondary Proc: _____ CPT: _____

Specialist Name: _____ Telephone #: _____

Facility: _____ Telephone #: _____

Level of care requested: Inpatient ☐ Day Patient/Surgery ☐ Amb Surgery Center (ASC) ☐
Admissions from non-acute settings: Inpatient (IP) Rehab ☐ SNF ☐
Anticipated or actual admit date: ____/____/_____Anticipated # days: _____

AUTHORIZATION DECISION (do not write in this section)

Primary ICD-9 Code _____ Primary CPT Code _____ OHP Line _____

Secondary ICD-9 Code _____ Secondary CPT Code _____ OHP Line _____

Level of Care Authorized: Inpatient ☐ Day Patient/Surgery ☐ ASC ☐ IP Rehab ☐ SNF ☐

Facility _____ Initial length of stay authorized _____days

Authorization # _____ Authorization valid until (date): _____/_____/_____

Authorized by: _____ Date: _____/_____/_____