

**CareOregon Advantage/OHMS
HOSPITAL AUTHORIZATION FORM
Fax to 541-956-5460**



Date ____/____/____ Name of person completing form _____

Phone _____ FAX _____

Member _____
Last First MI

DOB ____/____/____ DMAP ID# _____ SS # _____

Primary Dx _____ ICD-9 _____

Secondary Dx _____ ICD-9 _____

Primary Proc _____ CPT _____

Secondary Proc _____ CPT _____

Specialist/Attending _____ Telephone _____

Facility _____ Telephone _____

Level of care requested: ____ Inpatient ____ Day Patient/Surgery ____ Observation Bed Status

Anticipated or actual admit date ____/____/____ Anticipated lost days _____

POST-HOSPITALIZATION CARE

Call CareOregon Advantage/OHMS, 541-471-4208, for information on DME, medical supplies, home health care, home infusion, SNF, inpatient rehab and hospice care.

Hospital Authorization Decision (*do not write in this section*)

Level Of Care Authorized: ____ Inpatient ____ Day Patient/Surgery ____ Observation Bed Status

Facility _____ Attending/Specialist _____

Authorization # _____ Length Of Stay Authorized _____ days

Authorization valid until _____

- If additional days are needed, call _____ or toll free at _____ with clinical information.
- Authorization depends on CareOregon Advantage membership when services are provided.

Authorized by _____ Date _____