



FACILITY AUTHORIZATION FORM
CareOregon Advantage (Plus/Star) and OHP (Plus/Std) Members
Revised June 3rd, 2010
Fax Form and Chart Notes to: 503-416-3713 or 1-888-272-9315

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

Clinic Name: _____ From: PCP Office Spec Office

Telephone #: _____ Fax #: _____

Member Name: _____/_____/_____/_____/_____/_____
Last First MI DOB: ____/____/____

Subscriber ID#: _____ OHP Plus: OHP Standard: Advantage Plus: Advantage Star:

In order to process your request correctly, provide accurate and complete dx and proc information!

Primary Dx: _____ ICD-9: _____

Primary Proc: _____ CPT: _____

Secondary Dx: _____ ICD-9: _____

Secondary Proc: _____ CPT: _____

Additional Proc: CPT: _____ CPT: _____ CPT: _____

COMORBID CONDITIONS:

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!*

Specialist Name: _____ **Clinic:** _____

Telephone #: _____ Fax #: _____

Facility Name: _____ **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: _____