OFFICE/CLINIC AUTHORIZATION FORM

(Specialist, Therapist, Ancillary Providers)
CareOregon Advantage (Plus/Star) and OHP (Plus/Std) Members
Revised June 3rd, 2010
Fax Form and Chart Notes to: 503-416-3724 or 1-888-272-9315

Name of Person Completing Form: _____Date: ____/____/_____
Clinic Name: _____ From: PCP Office □ Spec Office □

Telephone #: _____ Fax #: _____

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

Subscriber ID#: _____OHP Plus: □ OHP Standard: □ Advantage Plus: □ Advantage Star: □

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

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!*

REQUEST AUTHORIZATION TO: *(See Authorization Guidelines to determine IF an auth is required)*

Provider Name: _____Clinic: _____
Address: _____

Telephone #: _____ Fax #: _____

REQUEST AUTHORIZATION FOR:
Specialist office visits: Diagnostic consult: □ **OR** Office visits: _____# of visits
Specialist office procedures: Primary CPT code: _____ Secondary CPT code: _____

Bariatric Center evaluations: _____# of visits **(the following information is needed to process request)**
Mbr weight: _____lbs as recorded on (date) _____/_____/_____, Mbr height: _____ BMI: _____
Mbr age: _____yrs. Does mbr have Type 2 diabetes: yes □ no □
CPT code: _____ CPT code: _____ CPT code: _____ CPT code: _____

Outpatient Therapies: Evaluation: P.T.□ O.T.□ S.T.□ Reason for eval: _____
Treatment: #PT _____; CPT Code: _____; _____
#OT_____; CPT Code: _____; _____
#ST _____; CPT Code: _____; _____
*Tx auth requests **must** include therapy evaluation results & all other relevant clinical information.*