

# CareOregon Advantage/OHMS Prior Authorization Form (referral to a provider)



Today's date \_\_\_\_\_

Member's name \_\_\_\_\_  
Last First MI

Member's DMAP ID# \_\_\_\_\_ DOB \_\_\_\_\_

Primary ICD-9 code \_\_\_\_\_ Secondary ICD-9 code (if applicable) \_\_\_\_\_

Print name of person completing this form \_\_\_\_\_

Requesting Clinic/Provider \_\_\_\_\_

Clinic phone \_\_\_\_\_ Clinic fax \_\_\_\_\_

## STEP 1

Verify member's CareOregon Advantage eligibility on QNXT View

[www.careoregon.org/provider/qnxt.html](http://www.careoregon.org/provider/qnxt.html)

Service(s) requested \_\_\_\_\_

Number of visits requested \_\_\_\_\_

## STEP 2

**Reason for prior authorization** (check **one**)

- Benefit exception. Fax chart notes to justify exception request.
- Benefit requires prior authorization.
- Non-par provider. Print on this form or fax reason why member should see out-of-network provider.

### Referral to:

Provider/Clinic Name \_\_\_\_\_

Address \_\_\_\_\_

Provider's phone \_\_\_\_\_ Fax \_\_\_\_\_

**Please fax this completed form to 541-956-5460.**

\*Please note that CMS guidelines allow up to 14 calendar days to approve or deny this request. If your request is urgent, please print a note on this form to alert us to your processing needs. Thank you.