Dental Hospitalization Authorization Form

(OHP and Medicare)

Fax form and chart notes to: 503-416-3713 or 888-272-9315

Verify service requires an authorization before completing the authorization request form.
The information is posted on the CareOregon website: careoregon.org

Person Completing the Form

Name: ______________________ ☐ Working at PCP office ☐ Working at Specialist Office

Date: ____________ Phone#: ____________________ Fax#: ______________

Member Name

Last Name: ______________________ First Name: ________________ MI: ____

DOB: ______________ Last Subscriber ID: ______________________________

PCP Name: ______________________ Clinic Name: ______________________

Provider Names

Specialist Name: ______________________________ Fax#: ______________

Clinic Name: ____

Facility Name: ______________________________ Tax ID#: ______________

Diagnosis (Dx) / Procedure Information

Primary DX: ______________________________ **DX Code:** ______________

Primary Proc: ______________________________ **CPT/CDT-4:** ______________

Secondary DX: ______________________________ DX Code: ______________

Secondary Proc: ______________________________ CPT/CDT-4: ______________

Additional Proc: CPT/CDT-4: __________ CPT/CDT-4: __________ CPT/CDT-4: __________

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)? Dx Code: ________ Narrative: ______________________

Please include relevant chart notes with this authorization request!

Level of Care Requested

☐ Ambulatory surgery center (ASC)

☐ Hospital day patient/surgery *Anticipated or actual date of service:* ______________________