RELINQUISHMENT OF AUTHORIZED SERVICES FORM

(Therapy, Acupuncture, Chiropractic)

FAX TO: 503-416-3724

Revised September 2019

Note: Only approved provider can relinquish visits. Members may contact customer service if they will not be receiving treatment from approved provider.

1. PERSON COMPLETING THE FORM:

Date: ___/___/_____ Name: ___________________Office Name: _______________________

Telephone #: _________________ ____ Fax #: __________________ ______

2. MEMBER NAME: _______________________________/ _____________________/ _____

Last First MI

DOB: ____/___/_______ Subscriber ID #:_______________________________

3. AUTHORIZED PROVIDER INFORMATION:

Authorization #: ____________________ _

Number of Visits Being Relinquished: _____________________

Number of Visits Used: _____________________

Last Date of Service : _____________________

Additional Comments: _____________________________________

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