

# Retro Facility Authorization Form

(OHP and Medicare) Revised June 15, 2017

Fax Form and Chart Notes to: 503-416-3713 or 888-272-9315

Verify service requires an authorization before completing the authorization request form.



CareOregon®

The information is posted on the CareOregon website: [careoregon.org](http://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: \_\_\_\_\_ Subscriber ID: \_\_\_\_\_  
PCP Name: \_\_\_\_\_ Clinic Name: \_\_\_\_\_

## Provider Names

Specialist Name: \_\_\_\_\_ Fax#: \_\_\_\_\_  
Clinic Name: \_\_\_\_\_  
Facility Name: \_\_\_\_\_

## 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

- (1) 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 comorbid condition(s)? Dx Code: \_\_\_\_\_ Narrative: \_\_\_\_\_

And, please **include relevant chart notes** with this authorization request!

## Level of Care Requested

Ancillary Dept.  Clinic/Office  Procedure Room  Ambulatory Surgery Center (ASC)  
 Hospital Day Patient/Surgery  Hospital Inpatient  
Anticipated or Actual Admit Date: \_\_\_\_\_ Anticipated# of Days: \_\_\_\_\_

## Reason for the Retro Request

Admin Delay - PA process  Eligibility Determination  Natural Disaster  
 Third Party  Litigation  Other