

Retro Office/Clinic Authorization Form

(Specialist, Therapist, Ancillary Providers) Revised June 15, 2017

Fax Form and Chart Notes to: 503-416-3724 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



CareOregon®

Person Completing the Form
Name: _____ <input type="checkbox"/> Working at PCP office <input type="checkbox"/> Working at Specialist Office Date: _____ Phone#: _____ Fax#: _____
Member Name
Last Name: _____ First Name: _____ MI: _____ DOB: _____ Subscriber ID: _____
Provider Information
Ordering Provider Name: _____ Clinic Name: _____ Fax#: _____ Rendering Provider Name: _____ Clinic Name: _____ Fax#: _____
Diagnosis (Dx) And Comorbid Conditions Information
Primary DX Code: _____ Secondary DX Code: _____ (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? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what is the comorbid condition(s)? Dx Code: _____ Narrative: _____ <i>And, please include relevant chart notes with this authorization request!</i> Services Requested (office visits; office procedures; ancillary): _____ Date of Service: _____ * Any CPT code entered within the range of 99211-99215 will make this authorization valid for that entire range of CPT codes. * New patient office visits do not require an authorization if that patient has not been seen within the last 3 years. * CPT Codes Are Required. Please List CPT Code(s) Being Requested For All Services, Along With The # For Each: CPT Code: _____ # _____ CPT Code: _____ # _____ CPT Code: _____ # _____ CPT Code: _____ # _____ CPT Code: _____ # _____ CPT Code: _____ # _____
Bariatric Center Evaluations
If the CPT codes provided above are for bariatric evaluation, please provide the following REQUIRED information: Mbr weight: _____ lbs as recorded on (date): _____ Mbr height: _____ BMI: _____ Mbr age: _____ yrs. Does mbr have Type 2 diabetes? <input type="checkbox"/> Yes <input type="checkbox"/> No
Outpatient Therapies
Please provide CPT codes along with the # of visits for each therapy code: PT – OT – ST: No authorization required for evaluations with an ATL diagnosis which pairs with CPT code. CPT Code: _____ # _____ CPT Code: _____ # _____ CPT Code: _____ # _____ CPT Code: _____ # _____ CPT Code: _____ # _____ CPT Code: _____ # _____ CPT Code: _____ # _____ CPT Code: _____ # _____ CPT Code: _____ # _____ Treatment auth requests must include therapy evaluation results & all other relevant clinical information. Reason For Retro Request: <input type="checkbox"/> Admin delay-PA process <input type="checkbox"/> Eligibility determination <input type="checkbox"/> Litigation <input type="checkbox"/> Natural disaster <input type="checkbox"/> Other