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.

The information is posted on the CareOregon website: *careoregon.org*

Person Completing the Form

Name: _____ ☐ Working at PCP office ☐ Wortking 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