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: _____ ◯ Working at PCP office ◯ 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? ☐ Yes ☐ No

If yes, what is the comorbid condition(s)? Dx Code:_____ Narrative: _____

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

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? ☐ Yes ☐ 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: ◯ Admin delay-PA process ◯ Eligibility determination ◯ Litigation
◯ Natural disaster ◯ Other