FACILITY AUTHORIZATION FORM

Revised **March 15, 2017**

Fax Form and Chart Notes to: **503-416-3713 or 1-888-272-9315**

Effective May 1, 2017, all prior authorization requests must be submitted via OneHealthPort for outpatient services

Verify service requires an authorization before completing the authorization request form.
The information is posted on the CareOregon Website @ www.careoregon.org

1. PERSON COMPLETING THE FORM

Date: ____/____/_____ Name: _____working @ PCP Office ☐ Specialist Office ☐

Telephone #: _____ Fax #: _____

2. MEMBER NAME: _____/ _____/_____
Last First MI

DOB: ____/____/_____ Subscriber ID#: _____

PCP Name: _____; Clinic: _____

3. PROVIDER NAMES:

Specialist Name: _____ Fax #: _____

Clinic Name:_____

Facility Name: _____

4. 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: _____

5. COMORBID CONDITIONS:

Does the member have a comorbid medical condition that is (1) under the best possible management, but (2) it is <u>not controlled</u>, and (3) providing this service will <u>significantly</u> improve the condition? ☐ **yes** ☐ **no**

If yes, what is the co-morbid condition(s)?Dx Code:_____Narrative_____

*And, please **<u>include relevant chart notes</u>** with this authorization request!*

6. 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 # days: _____