RETRO FACILITY AUTHORIZATION FORM

Revised **June 15, 2017**

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

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: _____

7. REASON FOR RETRO REQUEST:

☐ Admin delay-PA process ☐ Eligibility determination

☐ Natural disaster ☐ Third Party ☐ Litigation

☐ Other