Inpatient - Prior Authorization Form

Revised June 12, 2019

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

Day surgery and out patient services must be submitted via OneHealthPort.
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 ◯ Working 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: _____ Tax ID#: _____

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

☐ Hospital Inpatient:

Anticipated or actual admit date: _____ Anticipated # of days: _____