Dental Hospitalization Authorization Form

(OHP and Medicare)

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

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: _____ Last 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

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 co-morbid condition(s)? Dx Code: _____ Narrative: _____

Please include relevant chart notes with this authorization request!

Level of Care Requested

◯ Ambulatory surgery center (ASC)

◯ Hospital day patient/surgery *Anticipated or actual date of service:* _____