

Referral and authorization



Retroactive Date call/fax received by _____

Referral Inpatient Outpatient
 Standard authorization (completed within 14 days of receipt.)

Expedited (Choose ONLY if you are attesting that waiting for a decision under the standard time frame could place the

enrollee's life, health or ability to regain maximum function in serious jeopardy. Completed within **72 hours** of receipt.)

Section 1 Patient information

*** Required information**

Name	Date of birth	OHP Client ID #	Group #
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Section 2 Healthcare provider/on call doctor information

Name*	Clinic phone	Clinic fax
TIN #	Contact	

Section 3 Specialist Information

Name*	Clinic phone	Clinic fax	
Clinic address	City	State	Zip
TIN #	Contact		

Section 4 Facility Information

Name*	Clinic phone	Clinic fax
TIN #	Contact	
Admit date	Discharge date	

Section 5 Additional authorization/referral information

ICID10 code/s				
HCPC code/s				
CPT code/s				
Date span requested _____ to _____	# of visits/inpatient nights requested	Is this for a second opinion? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Comments				

Questions? Call 541-215-1208

Ready to submit? Mail: P.O. Box 518, Pendleton, OR 97801 Fax: 541-215-1207

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For EOCCO use only:

Authorization number _____ Denial number _____