Cascade Health Alliance

2909 Daggett Ave. Suite 225, Klamath Falls, OR
Phone: 541-883-2947 FAX: 541-882-6914

AUTHORIZATION REQUEST FORM

Print legibly
INCOMPLETE REQUESTS WILL BE RETURNED

THIS AUTHORIZATION IS NOT A GUARANTEE OF PAYMENT

PAYMENT WILL BE BASED ON OHP BENEFITS IN EFFECT THE TIME OF SERVICE, MEMBER ELIGIBILITY, AND MEDICAL NECESSITY

PROVIDER PHONE #_____   **PROVIDER FAX #** _____

AUTH STATUS: STANDARD_____   **URGENT**_____   **RETRO**_____

DATE:	INDIVIDUAL COMPLETING FORM:		PHONE #	
PATIENT NAME:		BIRTHDATE:	ID #	
ORDERING PROVIDER:		PROVIDER /FACILITY REFERRED TO:		
REASON FOR REFERRAL				
ICD-10 DIAGNOSIS CODE(S) * REQUIRED. *:				
DATE OF SERVICE:		RETRO DATE OF SERVICE:		

[   ] Please check here if Provider is out of area and then mark the following:
[   ] Service not available in service area [   ] Continuity of Care [   ] Appt. not available for _____weeks in service area

REQUIRED Procedure(s) **CPT**_____**- #** requested _____, **CPT**_____**- #** requested _____

                      CPT_____**- #** requested _____, **CPT**_____**- #** requested _____

OR

          HCPC CODES: _____-#requested _____   **HCPC CODES:** _____-#requested _____

          HCPC CODES: _____-#requested _____   **HCPC CODES:** _____-#requested _____

OUTPATIENT STAY: _____   **INPATIENT STAY:** (Hospital, SNF, etc.) _____

Length of Stay_____   OTHER Services: _____

Home Health Skilled Nursing Visits: (i.e. .: 2x/wk x 2 weeks): _____VISITS Per Week for _____WEEK(s)

THERAPIES (Please mark all that apply):   **PT**_____   **OT** _____   **ST**_____

REQUESTING VISITS (e.g.: 2x/wk x 2 weeks): _____VISITS Per Week for _____WEEK(s)

Other Information_____

_____
Physician Signature

CCCDataCM 10/17