

CASCADE COMPREHENSIVE CARE

BH FAX: 541-851-2069

2909 Daggett Ave. Suite 200, Klamath Falls, OR
541-883-2947

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