CASCADE HEALTH ALLIANCE, LLC FAX: 541-882-6914
2909 Daggett Ave. Suite 225, Klamath Falls, OR
541-883-2947

AUTHORIZATION REQUEST FORM

PRINT LEGIBLY

INCOMPLETE REQUESTS WILL BE RETURNED

THIS AUTHORIZATION IS NOT GUARANTEE OF PAYMENT

PAYMENT WILL BE BASED ON OHP BENEFITS IN EFFECT AT THE TIME OF SERIVCE, MEMBER ELIGBILITY, AND MEDICAL NECESSITY

PROVIDER PHONE# _____ PROVIDER FAX #_____

REQUIRED*

DATE:	*INDIVIDUAL COMPELETING FORM:	*PHONE#
*PATIENT NAME:	*BIRTHDATE:	*ID#
*REQUESTING PROVIDER:	*REFERRED TO PROVIDER OR FACILITY:	
ICD10 DIAGNOSIS CODE FOR MEDICAL		

REQUESTED SERVICE CODES REQUIRED*

*PROCEDURE CODE	*TOOTH#	*QUADRANT	*SURFACE

CHA has 14 days from the date of receipt to approve or deny non emergent requests. If additional time is needed we may have a possible extension of up to 14 additional calendar days if the Member, Member Representative or the Provider requests the extension; or if CHA justifies (to OHA upon request) a need for additional information and how the extension is in the member's interest.
CHA will process all URGENT requests within 3 days for the receipt of the request.