OHSU Health -Health Related Services Request Form

DATE OF REQUEST: _____/_____/_____ **Email to: ohsuhscareteam@ohsu.edu**

Member Name: _____

DOB: _____/_____/_____ **Member ID# _____**

Address: _____

Phone Number: _____ **E-Mail: _____**

Requestor of Service:_____

Phone: _____ Fax: _____

Service Provider: _____ Phone: _____

Contact Name: _____ Fax: _____

Item Description

COST:
$

Dx code pertaining to request:

Service/Treatment Goal:

Cost Savings:

****For OHSU Health Services use Only** - Final Determination**

☐ Approved ☐ Denied ☐ Incomplete

Notes:

Case Management Notification: ☐ Member ☐ Requestor ☐ PCP ☐ Service Provider

Notified by: ☐ Fax ☐ Phone ☐ Mail ☐ E-Mail Notified by: _____

Approval/Denial Date _____/_____/_____ **Final Cost of Service:** _____

Please note that these funds may be discontinued at any time. If other benefits are secured that would cover the same need, funding will be discontinued; and flexible services are intended to cover one time need or limited duration of ongoing needs.

Determinations are final and cannot be appealed

https://www.ohsu.edu/health-services 1- 844-827-6572