OHSU Health Services

OHSU Health Services
Referral and Authorization

Phone 844-931-1774 Fax 833-949-1887

PO Box 40384 Portland, OR 97240

☐RUSH ☐RETRO

☐ Referral ☐ Service Authorization **☐ Inpt ☐ Outpt**

Patient Information * = Required Information

Patient Name_____ DOB _____

*OHP Client ID # _____ Group # _____

PCP/On Call Doctor Information

PCP/On Call Doctor _____ *TIN # _____

Ph#_____Fax # _____Contact _____

Specialist Information

Specialist Name _____ *TIN# _____

Ph#_____Fax# _____Contact _____

Address/Location_____

Facility Information

Facility _____ *TIN #_____

Ph # _____ Fax#_____Contact _____

Admit Date_____Discharge Date_____

Additional authorization/referral information

ICD10 code(s)_____ _____ _____ _____ _____HCPC code(s)_____ _____ _____ _____ _____

CPT code(s) _____ _____ _____ _____ _____ _____ _____ _____

Date span requested _____ to _____ #of visits/Inpt nights requested_____

Is this for a second opinion Yes No

Are you referring to an Out of Network Provider? Yes No If Yes, I attest this is the only Provider who can treat this condition

Comments:

OHSU Health Services use only:

Authorization Number _____ **Denial Number**_____