OHSU HealthServices

Referral and Authorization

Phone: 844-931-1774 Fax: 833-949-1887
PO Box 40384 Portland, OR 97240

☐ RUSH (ONLY for cases in which a provider indicates that following the standard time frame could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function.

☐ Referral ☐ Retro ☐ Inpatient ☐ Outpatient

Patient Information

* = **Required Information**

Patient Name DOB _____

*OHP Client ID # _____ Group # _____

PCP/On Call Doctor Information

*PCP/On Call *TIN# _____ *NPI _____

Ph # Fax# Contact

Specialist Information

*Specialist *TIN# _____ *NPI _____

Ph # _____ Fax# Contact _____

Address/location_____

Facility Information

*Facility *TIN# _____ *NPI _____

Ph # Fax# Contact _____

Admit Date Discharge Date

Additional authorization/referral information

ICD-10 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

If yes, I attest this is the only provider who can treat this condition ☐

Comments:

OHSU Health Services use only:

Authorization Number _____**Denial Number**_____