OHSU Health Services

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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 members 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 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**_____