



RUSH RETRO

Call/fax received by _____

PO Box 40384 **Commercial** Authorization/Referrals
Portland, OR 97240 (503) 243-4496 (800) 258-2037 Fax (503) 243-5105

Date call/fax received _____
High Order Key _____

- PPO/Indemnity Service Authorization ODS MHN First Choice
- MC/POS Referral PHCS PPO Next No Network

Patient Name _____ DOB _____ Insurance ID # _____

Insured Name _____ Group # _____ Group Name _____

PCP/On Call Doctor _____ TIN # _____

Ph # _____ Fax # _____ Contact _____

Specialist Name _____ TIN# _____

Ph# _____ Fax# _____ Contact _____

Facility _____ TIN # _____ Ph # _____ Contact _____

ICD9 code(s) _____ CPT code(s) _____ Admit Date _____

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

Comments _____

*****BELOW TO BE COMPLETED BY ODS*****

Current Eligibility _____ Related Referral # _____ Disclaimer quoted? Yes

Chart notes requested _____ Recv'd _____ Comments _____

PCP on Panel? Yes No Specialist on Panel? Yes No Facility on Panel? Yes No

Requested Chart/Progress/Xray/Lab/Other _____ notes on _____ from _____ Received on _____

Authorized Not Authorized Partially Authorized Additional Info Requested

*Requesting provider notified of auth status w/in 48hrs on _____ Contact Name _____

APPROVAL: Authorization # _____ *Quote current disclaimer for services and eligibility.*

of visits/nights _____ Date Span _____ Procedure _____

Contact _____ Phone # _____ Date _____ Consultant/Director Review Date _____

Approved by _____ PN done Date _____ Data Entry Date _____

DENIAL: Denial # _____ *Request is being denied for the following reason(s):*

Member Not Eligible Out of Network Provider Out of Network Facility Not a Covered Benefit

Med Necessity Not Established Plan Benefits exhausted OHP Comorbidity Checked Other _____

Contact _____ Phone # _____ Date _____ Consultant/Director Review Date _____

Denied by _____ PN done Date _____ Data Entry Date _____

Comments _____