



Community Health, Inc.
Referral and Authorization

Oregon Health Plan		
<input type="checkbox"/> RUSH <input type="checkbox"/> RETRO <input type="checkbox"/> REFERRAL <input type="checkbox"/> AUTHORIZATION <input type="checkbox"/> PLUS <input type="checkbox"/> STANDARD		
Call/fax received by	Date call/ fax received	
Patient Name: Last	First	M.I.
DOB		
OHP Client ID#	OHP Group #	
PCP/On-call doctor	TIN:	
Phone	Fax	Contact
Specialist name	TIN:	
Phone	Fax	Contact
Facility	TIN:	
Phone		
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? <input type="checkbox"/> Yes
Chart notes requested	Received	Comments
PCP on Panel? <input type="checkbox"/> Yes <input type="checkbox"/> No / Specialist on Panel? <input type="checkbox"/> Yes <input type="checkbox"/> No / Facility on panel? <input type="checkbox"/> Yes <input type="checkbox"/> No		
OHP Line #	Prior related referral #(s)	
Requested Chart/Progress/X-ray/Lab/Other _____ notes on _____ from _____ Received on _____		
<input type="checkbox"/> Authorized <input type="checkbox"/> Not authorized <input type="checkbox"/> Partially authorized <input type="checkbox"/> Additional info requested		
*Requesting provider notified of auth. status within 48 hours on _____ Contact Name _____		
APPROVAL:	Authorization # _____	Quote disclaimer for services and eligibility.
# of visits/nights _____	Date span _____	Procedure _____
Contact _____ Phone _____	Date _____	<input type="checkbox"/> Consultant/Director Review Date _____
Approved by _____	<input type="checkbox"/> PN done Date _____	<input type="checkbox"/> Data Entry Date _____
DENIAL:	Denial # _____	Request is being denied for the following reason(s):
<input type="checkbox"/> Member not eligible <input type="checkbox"/> Out of network provider <input type="checkbox"/> Out of network facility <input type="checkbox"/> Not a covered Benefit		
<input type="checkbox"/> Med necessity not established <input type="checkbox"/> Plan benefits exhausted <input type="checkbox"/> OHP comorbidity checked <input type="checkbox"/> Other		
Contact _____ Phone _____	Date _____	<input type="checkbox"/> Consultant/Director Review Date _____
Denied by _____	<input type="checkbox"/> PN done Date _____	<input type="checkbox"/> Data Entry Date _____
Comments		

Oregon Health Plan Authorization/Referrals
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OHP 01/2006