CASCADE COMPREHENSIVE CARE

FAX: 541-882-6914

2909 Daggett Ave. Suite 200, Klamath Falls, OR
541-883-2947

AUTHORIZATION REQUEST FORM

Print legibly

INCOMPLETE REQUESTS WILL BE RETURNED

THIS AUTHORIZATION IS NOT A GUARANTEE OF PAYMENT

PAYMENT WILL BE BASED ON OHP BENEFITS IN EFFECT THE TIME OF SERVICE, MEMBER ELIGIBILITY, AND MEDICAL NECESSITY

PROVIDER PHONE #______________________ **PROVIDER FAX #** ___________________________

DATE:	INDIVIDUAL COMPLETING FORM:		PHONE #
PATIENT NAME:		BIRTHDATE:	ID #
ORDERING PROVIDER:	PROVIDER OR FACILITY REFERRED TO:		
REASON FOR REFERRAL			
ICD-9 DIAGNOSIS CODE(S) * **REQUIRED.** *:			

CHART NOTES REQUIRED *

INITIAL CONSULT/OFFICE VISIT(S) Requested:________________(Number requested) **OR**

REQUIRED Procedure(s) **CPT**_______________**-** # requested __________, **CPT**_______________**-** # requested ________

CPT_______________**-** # requested __________, **CPT**_______________**-** # requested ________

OR

HCPC CODES: ____________-#requested _________ **HCPC CODES:** ____________-#requested ________

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_____Please check here if Provider is out of area and then mark the following:
[ ] Service not available in service area [ ] Continuity of Care [ ] Appt. not available for _______weeks in service area

OUTPATIENT STAY: _______ **INPATIENT STAY:** (Hospital, SNF,etc.) ___________________

Length of Stay_________________ OTHER Services: ______________________________________

Home Health Skilled Nursing Visits: (i.e. .: 2x/wk x 2 weeks): _____________VISITS Per Week for _________WEEK(s)

THERAPIES (Please mark all that apply): **PT**________ **OT** _______ **ST**_________

REQUESTING VISITS (e.g.: 2x/wk x 2 weeks): _____________VISITS Per Week for _______________WEEK(s)

Other Information____

____

Physician Signature

CCC Office Use Only

Date:_________Records Received: _____________
Case Manager: _____________ Approved/Denied Date_______
Reason: