CASCADE COMPREHENSIVE CARE

BH FAX: 541-851-2069
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 #** _____

AUTH STATUS: STANDARD_____ **URGENT**_____ **RETRO**_____

DATE:	**INDIVIDUAL COMPLETING FORM:**	**PHONE #**
PATIENT NAME:	BIRTHDATE:	ID #
ORDERING PROVIDER:	**PROVIDER /FACILITY REFERRED TO:**	
REASON FOR REFERRAL		
ICD-10 DIAGNOSIS CODE(S) * **REQUIRED.** *:		
DATE OF SERVICE:	**RETRO DATE OF SERVICE:**	

[ ] 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

REQUIRED Procedure(s) **CPT**_____**- #** requested _____, **CPT**_____**- #** requested _____

CPT_____**- #** requested _____, **CPT**_____**- #** requested _____

OR

HCPC CODES: _____-#requested _____ **HCPC CODES:** _____-#requested _____

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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

CCCDataCM 10/17