Referral and authorization

eocco
EASTERN OREGON COORDINATED CARE ORGANIZATION

☐ Retroactive ☐ Date call/fax received by _____

☐ Referral ☐ Inpatient ☐ Outpatient

☐ **Standard authorization** (completed within 14 days of receipt.)

☐ **Expedited** (**Choose ONLY** if you are attesting that waiting for a decision under the standard time frame could place the enrollee's life, health or ability to regain maximum function in serious jeopardy. Completed within **72 hours** of receipt.)

Please refer to the EOCCO Clinical Practice Guidelines & Referral and authorization Instructions for additional guidance.

Section 1 Patient information

*** Required information**

Name	Date of birth	OHP Client ID #	Group #

Section 2 Healthcare provider/on call doctor information

Name*	Clinic phone	Clinic fax
TIN #	Contact	

Section 3 Specialist Information

Name*	Clinic phone	Clinic fax	
Clinic address	City	State	Zip
TIN #	Contact		

Section 4 Facility Information

Name*	Clinic phone	Clinic fax
TIN #	Contact	
Admit date	Discharge date	

Section 5 Additional authorization/referral information

ICID10 code/s					
HCPC code/s					
CPT code/s					

Date span requested _____ to _____	# of visits/inpatient 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 that can treat this condition

X

Comments

Questions? Call 503-265-2940 or 888-474-8540

Ready to submit? *Mail:* P.O. Box 40384, Portland, OR 97240 Fax: 833-949-1886

eocco.com

For EOCCO use only:

Authorization number _____ Denial number _____