



Please send completed form to:

P.O. Box 40384 Portland, OR 97240

Dept/Ext: _____

Date Recv'd: _____

Transition of Care Request

Patient Name: _____ DOB: _____ ID# _____

PCP/On Call Doctor: _____ Ph# _____ Contact: _____

Specialist Name: _____ Ph# _____ Contact: _____

Facility: _____ Ph# _____ Admit Date: _____

ICD9 code(s): _____ CPT code(s): _____ If Pregnant, Due Date: _____

Previous Insurer: _____ Ph# _____ ODS Effective Date: _____

Reason for requesting Transition of Care: _____

*** Thank you for completing the top portion of this form, ODS will complete the rest. ***

Current Eligibility: _____ Disclaimer quoted? _____ Chart Notes Requested? _____

Chart notes Received? _____ Comments? _____

PCP on panel? Yes No Specialist on panel? Yes No Facility on panel? Yes No

Requested Chart/Progress/Xray/other _____ notes on _____ from _____ Received on _____

Authorized Not Authorized Partially Authorized Additional Info Requested

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

Mkg Manager Notification Name/Date: _____ ASO approval Date: _____

PR Manager Notification Name/Date: _____

Comments: _____

Transition of Care Request Approved: Authorization# _____

Quote current disclaimer for services and eligibility

Date Span: _____ Procedure: _____

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

Approved by: _____ PN done Date: _____ Date entry Date: _____

Comments: _____

Transition of Care Request Denied: Denial# _____

Request is being denied for the following reason(s):

Medical necessity for transition of care not established Other _____

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

Denied by: _____ PN done Date: _____ Date entry Date: _____

Comments: _____