



Community Health, Inc.  
Acupuncture Referral Request

Oregon Health Plan			
Referral valid from	to	(not to exceed 90 days)	
Today's Date			
Patient Name: Last	First	M.I.	
Phone (H)	(W)		
ID#	DOB		
<b>Requesting Provider/PCP:</b>			
Provider Name			
Clinic Name			
Address			
Phone	County		
Fax			
<b>Referred to:</b>			
Provider Name			
Clinic Name			
Address			
Phone	County		
Fax			
<b>Diagnoses/Reason for Referral</b>			
ICD9 Code(s)			
Dates of prior treatment: From		To	
Number of previous visits for this diagnoses		Results	
Number Additional visits requested		Treatment goal	
Continuing treatment plan			
Comments			

**INSTRUCTIONS** (No authorization required for first 20 sessions for covered services.)

Acupuncture Specialist: Complete Form and send to PCP.  
PCP: Fax form with referral to ODS Community Health, Inc. at 503.670.8349.  
Please retain in-patient records.

OHP 01/2006