



PO Box 40384
Portland, OR 97240

Commercial authorization/referral
(503) 243-4496 (800) 258-2037 Fax (503) 243-5105

Call/fax received by _____
Date call/fax received _____

Referral Service Authorization Retro Inpt Outpt

**If you require a rush Prior Authorization for a procedure being done within 48hrs, please call
ODS at (503) 243-4496 or (800) 258-2037)**

Patient Information

Patient Name _____ DOB _____ Insurance ID # _____

Insured Name _____ Group # _____ Group Name _____

PCP/On Call Doctor Information

PCP/On Call Doctor _____ TIN # _____

Ph# _____ Fax # _____ Contact _____

Specialist Information

Specialist Name _____ TIN# _____

Ph# _____ Fax# _____ Contact _____

Address/Location _____

Facility Information

Facility _____ TIN # _____

Ph # _____ Fax# _____ Contact _____

Admit date _____ Discharge date _____

Additional authorization/referral information

ICD9 code(s) _____

CPT code(s) _____

Date span requested _____ to _____ #of visits/Inpt nights requested _____

Comments _____

Below for ODS use only:

Authorization number _____ Denial number _____