



RUSH RETRO

PO Box 40384
Portland, OR 97240

Community Health, Inc. Referral and Authorization
(503) 243-4496 (800) 258-2037 Fax (503) 243-5105

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

Referral Service Authorization Plus Standard Inpt Outpt

Patient Information

Patient Name _____ DOB _____

OHP Client ID # _____ OHP Group # _____

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) _____ HCPC code(s) _____

CPT code(s) _____

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

Is this for a second opinion Yes NO

Comments _____

Below for ODS use only:

Authorization number _____ Denial number _____