HEALTH SYSTEMS DIVISION
Provider Services

Oregon Health Authority

# Request for Claim Review

Use this form to request review of Oregon Health Authority (OHA) or coordinated care organization (CCO) coverage decisions not related to contested case hearings or client appeals. Oregon Administrative Rules 410-120-1560, 410-120-1570 and 410-120-1580 apply.

- **For review of OHA decisions,** providers must be enrolled or under contract with OHA on the date of service (DOS) under review. OHA must receive your request within 180 calendar days of the original decision date.
- **For review of CCO decisions,** providers must be enrolled with OHA and/or the CCO on the DOS under review, and must have exhausted the CCO's appeal process. The Division must receive your request within **30 calendar days** of the CCO's decision about your appeal.

Send all required documents to:

- **Mail:** Provider Services, 500 Summer St NE E44, Salem OR 97301.
- **Secure email:** OHA.FFSOHPClaims@oha.oregon.gov (for OHA decisions) or OHA.AdministrativeReview@oha.oregon.gov (for CCO decisions).

## Requesting provider

Name _____ National Provider Identifier _____

Contact name _____ Contact phone _____

Contact email _____

## Service information

Member ID _____ Member date of birth (MM/DD/YYYY): _____

Member name (last, first MI): _____ DOS: From _____ To _____

## Decision information

Original decision date (MM/DD/YYYY): _____ Rendering Provider ID: _____

Tell us what the decision is related to (select one):

☐ Claim. Enter the Internal Control Number (ICN):

☐ Other (please specify):

## Reasons for review – Mark all that apply.

☐ Condition/treatment does not pair on the Prioritized List but should be covered for medical necessity reasons.

☐ Service is for a condition that meets the prudent layperson definition of an emergency medical condition.

☐ Service is diagnostic and should be covered even if not paired with a condition on a funded Prioritized List line.

☐ Other (please explain):

## Required documentation

☐ A completed one-page, commercially available claim form (e.g., CMS-1500, OHP 505, UB-04, ADA form). It should contain all information provided on the original claim received by OHA or the CCO.

☐ Proof of member eligibility and enrollment (with OHA or the CCO) on the date(s) of service.

☐ Relevant medical records/evidence-based practice data that supports your reason(s) for review **and** explains why you think the OHA or the CCO should reverse its decision. *Do not submit entire medical record.*