HEALTH SYSTEMS DIVISION
Provider Services

Oregon Health Authority

Request for Claim or Payment Authorization Review

Use this form to request review of Division, coordinated care organization (CCO) or prepaid health plan (PHP) 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 Division decisions,** providers must be enrolled or under contract with the Division on the date of service (DOS) under review. The Division must receive your request within 180 calendar days of the decision date.
- **For review of CCO/PHP decisions,** providers must be enrolled with the Division and/or the CCO/PHP on the DOS under review, and must have exhausted the CCO/PHP's appeal process. The Division must receive your request within 30 calendar days of the CCO/PHP's decision about your appeal to the CCO/PHP.

Mail with all required documents to: Provider Services, 500 Summer St NE E44, Salem OR 97301.

Requesting provider

Name _____ National Provider Identifier _____

Contact name _____ Contact phone _____

Contact fax _____ Are you currently enrolled with the Division? ☐ Yes ☐ No

Service information

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

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

Decision information – *Tell us what the decision is related to (select one):*

☐ Denial or limitation of payment. Enter the Internal Control Number (ICN): _____

☐ Overpayment determination. Enter the ICN: _____

☐ Service authorization. Enter the prior authorization number: _____

☐ Other (please specify): _____

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

Reasons for review – *Mark all that apply.*

☐ Condition/treatment pair should be covered

☐ Service is covered by the Citizen/Alien-Waived Emergency Medical program due to:
☐ labor/delivery or ☐ a sudden, severe condition that, if left untreated, would cause serious jeopardy, harm or impairment to the patient's health, bodily functions, or bodily organs/parts.

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

☐ Fee schedule or Medicaid Management Information System error

☐ Incorrect data items on denial (*e.g.*, wrong ID number, modifier, date of service, units or charges)

☐ Service is diagnostic

☐ Other (please explain): _____

Supporting documentation – *Attach all of the following documents.*

☐ Copy of the decision notice (*e.g.,* denial notice or remittance advice)

☐ Copy of the original claim or service authorization request

☐ Proof of client eligibility 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 Division should reverse its decision. *Do not submit entire medical record.*