



Referral Authorization Request

Phone: 541-485-2155

Lipa Fax: 541-485-0737

Medically Urgent

Instructions for Completion:

- Please print clearly.
- Complete all boxes marked with *.
- Requests with incomplete * areas will be returned without processing.
- Attach clinical notes, lab results, etc., to support the request.

Note: *If submitting Referral request via web Portal, chart notes supporting the request must be received by fax in order to begin processing the Referral.*

Referral Authorization Required for any of the following: (must choose ONE) *

- Out of Area Provider
 Non-participating Provider
 2nd Opinion consult
 Bariatric procedure

Reference:

Conditions currently covered for treatment by OHP may be found at:

<http://lipaline.lipa.net>

Patient Name:**ID #:*****From:** (Ordering PCP)**Office**

Name

Phone

Contact:***To:**

Specialist:

First Name

Last Name

Specialty:

For:***ICD-9 Code:*****ICD-9 Description:**

Service Desired:

CPT Code (if known / applicable):

***Type:**
(check one) Initial referral for this problem
 Follow-up referral (Note: OHP covered condition dx is required for follow-up specialist visits. Refer to LipaLine.)
***Referral Date Range:**

From:

To:

Requested number of visits:*Referring Office Comments:****For LIPA use only:****Previous referral #:**

Visits:

Dates:

To

Approval is not a guarantee of payment. Benefit eligibility must be in effect at the time services are rendered and all plan provisions will apply.

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