Community Health, Inc.

Acupuncture Referral Request

Oregon Health Plan		
Referral valid from	to	(not to exceed 90 days)
Today's Date		
Patient Name: Last	First	M.I.
Phone (H)	(W)	
ID#	DOB	
Requesting Provider/PCP: Provider Name		
Clinic Name		
Address		
Phone	County	
Fax		
Referred to: Provider Name		
Clinic Name		
Address		
Phone	County	
Fax		
Diagnoses/Reason for Referral		
ICD9 Code(s)		
Dates of prior treatment: From	To	
Number of previous visits for this diagnoses	Results	
Number Additional visits requested	Treatment goal	
Continuing treatment plan		
Comments		

INSTRUCTIONS (No authorization required for first 20 sessions for covered services.)

Acupuncture Specialist: Complete Form and send to PCP.
PCP: Fax form with referral to ODS Community Health, Inc. at 503.670.8349.
Please retain in-patient records.

OHP 01/2006