### Administrative Medical Examination/Report Authorization

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<th>11. Provider Name and Address</th>
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A Release of Information is Enclosed

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This individual and the Division ask your help in determining his/her medical condition. He/she is seeking assistance because of the following complaints:

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All medical reports must be written and must contain a diagnosis, prognosis, and supporting objective findings. Functional impairments (changes is physical/mental functioning as a result of illness, injury, medication or surgery) and expected duration should also be included. The reports will only be accepted from Medicaid enrolled licensed medical and osteopathic doctors, optometrists, licensed clinical psychologists, licensed clinical social workers, physical therapists or occupational therapists as requested by the local branch.

16. **Attached forms to be completed and returned:**

- [ ] Comprehensive Psychiatric or Psychological Evaluation - See attached form OMAP 729A
- [ ] Report on Eye Examination - Complete attached form OMAP 729C
- [ ] Medical Record Checklist - See attached form OMAP 729D
- [ ] Mental Residual Function Capacity Report - Complete attached form OMAP 729F
- [ ] Physical Residual Function Capacity Report - Complete attached form OMAP 729E
- [ ] Rating of Impairment Severity Report - Complete attached form OMAP 729G

**Billing Information:** In order to expedite services to this patient and payment to you, please return the report within 15 days to the branch office listed above. Use the ICD-9-CM diagnosis code V68.89. Send the HCFA-1500 billing form to OMAP, PO Box 14165, Salem, OR 97309. Hospitals send UB 92 to OMAP, PO Box 14956, Salem, OR 97309. Copying services send HCFA -1500 to OMAP 729 to P.O. Box 14165, Salem, Oregon 97309. **Relay the V68.89 diagnosis code to the Medicaid enrolled ancillary providers if additional OMAP covered outpatient diagnostic services (e.g. lab, X-ray, special studies) are needed.**
Caseworker Instructions for Completion of OMAP 729

All blanks must be completed

1. Patient’s Name ......................... Name of client to be seen by medical provider
2. Insured’s ID/Prime Number ......... Eight alpha/numeric character field
3. SSN ..................................... Client’s Social Security Number
4. Date of Birth ............................ Patient’s Date of Birth
5. Program ................................. Program (A1, 2, B3, D4, 5, P2, etc.)
6. Branch ................................. Branch number (2401, etc.)
7. Case Number ......................... Case number under which client is identified
8. Worker ID .............................. Worker Identification Code
9. Case Name ............................. Case name under which client is identified
10. Provider Number ...................... Medical provider number assigned by OMAP, found on PRV1
    (See Computer Guide for instructions on accessing PRV1)
11. Address Box ......................... Name and address of medical provider
12. Patient’s Complaint Area .......... List stated medical or mental conditions
13. Procedure Code ...................... Procedure code of selected exam or report
14. Description of Service ............ Description for selected examination or report from guidelines
15. Amount to be Billed ............... Amount to be billed for selected examination or report from guidelines
16. Needed Reports Boxes ............. If other 729s are used, check the appropriate box
17. Branch Name and Address ........ Legible branch name and mailing address
18. Worker’s Name ...................... Legible name of worker requesting examination or report
19. Date Requested ...................... Date 729 sent to medical provider
20. Telephone .............................. Legible telephone number of worker requesting report