Flexible Spending Request Form

Requester to complete the Member Information and Request Information and fax to clinical engagement 541-677-5881.
For questions, call clinical engagement 541-673-1462.

Requestor to Complete

MEMBER INFORMATION:

Member ID:

Members Name:

Member DOB:

If minor, Parent or Guardians

Phone Number:

Name: Physical Address:

Mailing Address if different:

REQUESTED INFORMATION:

Date Requested:

Requesting Provider/Person:

Assigned PCP:

RN Case Manager:

Description of Request and Why:

Purpose or Expected Benefit:

Clinical Engagement to Complete

REVIEW INFORMATION:

Date Reviewed:

Payment Method *(Select)*:

Medical Review Notes:

Estimated Cost of Request:

PO Sent to Finance Director:

Actual Cost of Request:

Date Sent to Finance:

Category:

Date Paid:

Coverage:

PCP Order Obtained:

Payment Instructions:

EMR PA Process Started:

Make Checks Payable To:

Phone Number:

Mail Checks To:

Medical Director's Signature:

Decision Date: