OHA COVER SHEET

Department of Children & Families

To: Your DCF Health Advocate **Fax:** 860-331-2499

Date: **Pages:**

DCF Social Worker/Office: **Phone:**

Re: OHA Authorization Form **CC:**

☐ Urgent ☐ For Review ☐ Please Comment ☐ Please Reply ☐ Please Recycle

DCF SOCIAL WORKER: Complete the box(es) below for each OHA Authorization form. Attach this cover sheet to the OHA Authorization and hand deliver or fax them to your DCF Health Advocate. Do not fax these documents to OHA.

Is there a private insurance denial? ☐ Yes ☐ No ☐ Don't know

If yes, specify date: _____

Is there a Medicaid insurance denial? ☐ Yes ☐ No ☐ Don't know

If yes, specify date: _____

DCF HEALTH ADVOCATE: Provide the commercial insurance information and Medicaid number in the space below. FAX this cover sheet and authorization form to OHA.

Commercial Insurance Name: _____

Policy #: _____ Group #: _____

Policy Holder's Name: _____

Medicaid Insurance #: _____