Relinquishment of Authorized Services Form

For therapy, acupuncture, chiropractic

Note: Only approved provider can relinquish visits. Members may contact customer service if they will not be receiving treatment from approved provider.

Fax to: **503-416-3724**

Person completing the form

Date: ____/____/_________ Name:______________________________

Office name: ______________________________

Telephone #: ______________________________ Fax #: ______________________________

Member information

Member name: ______________________________
Last *First* *MI*

DOB: _____/____/_________ Subscriber ID #: ______________________________

Authorized provider information

Authorization #:______________________________ Number of visits being relinquished: ______________

Will you be seeing member for services after today? ☐ Yes ☐ No

If no, **Final Date** of service: _____/____/_________

Additional comments: ______________________________

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