K Plan Letter Request

CareOregon®

Introduction

K Plan is a Medicaid funding source through the Department of Human Services that may be available for members with intellectual or developmental disabilities (DD). A member can request access to this funding through their DD Caseworker.

The K Plan request is a request for a denial letter issued by CareOregon stating the requested item or service is not covered by the member's Medicaid plan. This is a required part of the Oregon Developmental Disabilities Services (ODDS) funding process.

Eligibility

The member must be enrolled in a CareOregon affiliated CCO's Oregon Health Plan for primary or secondary coverage.

Eligible Members by enrollment type:

- Health Share of Oregon - CareOregon physical health
- Health Share of Oregon - Behavioral and dental health
- Jackson Care Connect - Physical and behavioral health
- Columbia Pacific CCO - Physical and behavioral health

Eligible Items/Services that are medical, billable, or considered DME are not eligible for K plan letters as they are covered services

Timeline

All requests must be submitted 10-14 business days prior to the date the denial letter is needed.

Process

In order to complete your request, please make sure:

- The form is legible and all fields are filled out
- The form is signed
- You are only making one request per form
- Handwritten forms are legible and clear

Following these steps ensures that your request can be processed as efficiently as possible.
Thank you.

Fax completed forms to: **503-416-4728**

Health Related Services
Voicemail line: **503-488-2808**

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Member Information

Date (mm/dd/yyyy): ____________________

CCO:

Last name: ____ First name: ______________________________

Member ID: ____ DOB: ____________________________

Street address: ____

Mailing address
(if different from above): ____

Phone #: ____

Diagnosis relevant to request (diagnosis must be accompanied by ICD-10 or DSM code):

____

Requesting Party Information

Organization name: ____

Name: ____ Email: ______________________

Office fax: ___________________________________ Office phone: _______________________________

Requested Details and Information

Please submit one request per denial letter needed.

Item or service requested: ____ Quantity: __________

Date needed: _________________ Estimated cost: ____

Primary Care Team Name (printed): ____

Primary Care Team Signature: ____