HealthChoice
3545 N.W. 58th St., Ste. 600, Oklahoma City, OK 73112
Phone: 405-717-8879 or 800-543-6044, ext. 8879
Fax: 405-949-5459 or 405-949-5501

DME REFERRAL INFORMATION

This form must be completed and accompany all requests. Incomplete forms will not be reviewed.

Billing Provider: _____ Date: _____

Billing Address: _____

TIN: _____ Contact Person: _____

Phone: _____ Fax: _____

Patient: _____ DOB: _____

Member: _____ Member ID: _____

Physician: _____ Phone: _____

NOTE: Must include physician's signed documentation of medical necessity in order to complete review (i.e., letter of medical necessity, CMN and/or script)

ICD code and summary of care:

_____

_____

HCPC code(s) must include descriptions for all miscellaneous codes:

_____

_____

Rental: Yes ☐ No ☐ **Purchase:** Yes ☐ No ☐

NOTE: Any changes or additional services require updated information.

Date(s) of Service being requested: _____ If the date of service has already occurred, it must be included to complete review.

**** All information is required for review. Information provided is private and confidential. ****

NOTE: These benefits are applicable only if the patient is an eligible enrolled member of a HealthChoice plan. All benefits are subject to the deductible, coinsurance and policy provisions. Please verify benefits and eligibility by calling the medical claims administrator toll-free at 800-323-4314.

MEDICARE PATIENTS: If HealthChoice is the supplemental insurance carrier, authorization from HealthChoice is not required. Please contact Medicare.

********** **FOR HCMU USE ONLY – DO NOT WRITE BELOW THIS LINE** **********

Reviewed By: _____ Reviewed By: _____

Date: _____ Date: _____

Comments:

_____

_____