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

HOME HEALTH REQUEST

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: ______________

HCPCS Code(s): ______________________________ Diagnosis Code: ______________

CPT Code(s): ______________________________

Physician's Name: ______________________________

Current physician's order copy attached: YES ☐ NO ☐

 # 1 most recent clinical note must accompany request:

PLEASE LIST TOTAL # OF SERVICES AND FREQUENCY REQUESTED FOR EACH SPECIALTY (EX: 1 W 1, 2 W 2)

SNV _____ Frequency: ____ W ____, ____ W ____ PT _____ Frequency: ____ W ____, ____ W ____

OT _____ Frequency: ____ W ____, ____ W ____ ST _____ Frequency: ____ W ____, ____ W ____

START DATE ______________________ ENDING DATE ______________________

 # 2 most recent clinical notes must accompany request:

PLEASE LIST TOTAL # OF SERVICES AND FREQUENCY REQUESTED FOR EACH SPECIALTY (EX: 1 W 1, 2 W 2)

SNV _____ Frequency: ____ W ____, ____ W ____ PT _____ Frequency: ____ W ____, ____ W ____

OT _____ Frequency: ____ W ____, ____ W ____ ST _____ Frequency: ____ W ____, ____ W ____

START DATE ______________________ ENDING DATE ______________________

 # 3 most recent clinical notes must accompany request:

PLEASE LIST TOTAL # OF SERVICES AND FREQUENCY REQUESTED FOR EACH SPECIALTY (EX: 1 W 1, 2 W 2)

SNV _____ Frequency: ____ W ____, ____ W ____ PT _____ Frequency: ____ W ____, ____ W ____

OT _____ Frequency: ____ W ____, ____ W ____ ST _____ Frequency: ____ W ____, ____ W ____

START DATE ______________________ ENDING DATE ______________________

**** 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.