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

MENTAL 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: _____

ICD-10 Diagnosis:

_____

_____

_____

Stressors:

_____

_____

_____

_____

_____

History of psychiatric treatment – Dates and number of previous hospitalizations and length of time patient has been in outpatient care: _____

_____

_____

_____

Significant diagnostic changes: _____

_____

_____

_____

_____

_____

Describe current symptoms that are the primary focus of treatment and progress in treatment: _____

_____

_____

_____

_____

_____

Current Medications – Name, dosage frequency and response to medications: _____

_____

_____

Treatment Goals – Include time frame to meet goals: _____

_____

_____

Describe the proposed treatment and why you consider it medically necessary at this time: _____

_____

_____

_____

Please indicate type of services, number of sessions, frequency of sessions, start and stop date:

CPT code _____ Number of sessions _____ Frequency of sessions _____ Start date _____ Stop date _____

CPT code _____ Number of sessions _____ Frequency of sessions _____ Start date _____ Stop date _____

CPT code _____ Number of sessions _____ Frequency of sessions _____ Start date _____ Stop date _____

Intensive Outpatient Program:

Number of sessions _____ Frequency of sessions _____ Start date _____ Stop date _____

Select one billing code: S9480_____RevCode: 0905 _____RevCode: 0906 _____

Estimated discharge date: _____

Discharge plan: _____

_____

_____

_____

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If you are requesting a retroactive review, please list all dates of services and CPT codes you are requesting authorization for below.

_____

_____

_____

Signature: _____ 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.

Rev. Jan. 2019