



3545 NW 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

ORAL SURGERY REQUEST

This form must be completed and accompany all requests. Incomplete forms will be returned for completion.

Billing provider _____ Date _____

Billing address _____

Facility _____

TIN _____ Contact person _____

Phone _____ Fax _____

Patient _____ DOB _____

Member _____ Member ID _____

Dates of Service: Beginning _____ Ending _____

Summary of case/diagnosis codes _____

Request (CPT/HCPCS codes) _____

NOTE: Physician letter of medical necessity or office notes are required to document the above requested information.

**** 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 *****

CERT MET / PENALTY APPLIES

Start date _____ Approved by _____

Date _____

COMMENTS _____
