



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

PROTON BEAM RADIATION 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: _____

Diagnosis code(s): _____

HCPCS code(s): _____

CPT code(s): _____

Number of services to be rendered: _____

Beginning date of service: _____ Ending date of service: _____

NOTE: Please provide a physician’s letter of medical necessity or clinical office notes outlining the previous treatments provided to the patient.

Comments:

**** 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.