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

TREATMENT/MEDICATION REQUEST

DO NOT USE THIS FORM FOR MEDICATIONS BEING PICKED UP AT A PHARMACY

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

Date _____

Requesting provider _____ Contact person _____

Phone _____ Fax _____

Servicing Facility Information

Facility name _____

Address _____

TIN _____ Contact person _____

Phone _____ Fax _____

Patient _____ DOB _____

Member _____ Member ID _____

Name of therapy requested _____

Number of services to be rendered _____

ICD code(s) _____

HCPCS code(s) _____

CPT code(s) _____

Beginning date _____ Ending date _____

Comments _____

_____

_____

_____

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NOTE: A physician's letter of medical necessity or six months previous conservative treatment notes must accompany the initial request. Documentation of clinical response must accompany all other requests.

**** 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.