HEALTHCHOICE

TMD/TMJ Authorization Form

Phone 1-405-717-8879
In-State 1-800-543-6044

Fax # 1-405-717-8947

Date: ____________________

Physician: ____

Address: ____

Network ☐ Non-Network ☐

Contact Person: ____

Phone: ______________________________ Fax: __________________

Patient: ______________________________ DOB: ______________________

Member: ______________________________ Member ID #: ____________________

Diagnosis: ____

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Note: Physicians letter of medical necessity or office notes may be utilized to document the above requested information.

Start Date: ____________________ Approved By: ____________________________________

Date: ____________________________________

********************************FOR HCMD USE ONLY***********************

COMMENTS:

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These benefits are applicable only if the patient is eligible for the Employees Group Insurance program and are subject to ALL POLICY PROVISIONS. Please remember to verify benefits and eligibility by calling 1-800-782-5218.

Rev. July, 2008