

# HEALTHCHOICE

3545 NW 58<sup>th</sup>, Suite 500, Oklahoma City, OK 73112  
 Phone: 1-800-543-6044 or 1-405-717-8879  
 FAX: 1-405-717-8947 or 1-405-717-8935

## INFUSION THERAPY REQUEST

**This information is private and confidential.**

(◆) Billing Provider: \_\_\_\_\_ (◆) Date: \_\_\_\_\_

(◆) Billing Address: \_\_\_\_\_

(◆) TIN: \_\_\_\_\_ Contact Person : \_\_\_\_\_

Phone: \_\_\_\_\_ (◆) Fax # : \_\_\_\_\_

Contracted HHC Agency : \_\_\_\_\_

(◆) Patient: \_\_\_\_\_ (◆) DOB: \_\_\_\_\_

(◆) Member: \_\_\_\_\_ (◆) Member ID #: \_\_\_\_\_

Diagnosis & Summary of Care: \_\_\_\_\_

(◆) Physician's Name: \_\_\_\_\_

Physician's Orders: \_\_\_\_\_

<p style="text-align: center;"><b><u>CERT MET <input type="checkbox"/> / PENALTY APPLIES <input type="checkbox"/></u></b></p> <p>Approve IV _____ per diem plus fee schedule of all meds for DOS _____ to _____. Per diem inclusive of all SNV and supplies. Will need updated request if therapy is continued with updated Rx from physician.</p>	<p style="text-align: center;"><b><u>CERT MET <input type="checkbox"/> / PENALTY APPLIES <input type="checkbox"/></u></b></p> <p>Approve IV _____ per diem plus fee schedule of all meds for DOS _____ to _____. Per diem inclusive of all SNV and supplies. Will need updated request if therapy is continued with updated Rx from physician.</p>
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**NOTE:** These benefits are applicable only if the patient is eligible for HealthChoice, and are subject to ALL POLICY PROVISIONS. Please remember to verify benefits and eligibility by calling 1 (800) 782-5218.

**MEDICARE PATIENTS:** If HealthChoice is supplement, all services requested must initially be approved by Medicare.

(◆) **DENOTES INFORMATION REQUIRED TO COMPLETE REVIEW FOR CERTIFICATION**