

HEALTHCHOICE

3545 NW 58th, 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

MEDICATION/TREATMENT REQUEST

This information is private and confidential.

(◆) Billing Provider: _____ (◆) Date: _____

(◆) Billing Address: _____

(◆) TIN: _____ Contact Person: _____

Phone : _____ (◆) Fax: _____

(◆) Patient: _____ (◆) DOB: _____

(◆) Member: _____ (◆) Member ID #: _____

(◆) Diagnosis: _____

(◆) Name of Therapy Requested plus CPT/HCPCS Code: _____

(◆) Number of Services to be Rendered: _____

Previous Conservative Treatments: _____

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

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

CERT MET / PENALTY APPLIES

Start Date: _____ End Date: _____ Approved By: _____

Date: _____

COMMENTS: _____

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**