

HEALTHCHOICE

DME REFERRAL INFORMATION

Phone: 1-800-543-6044 or 1-405-717-8879

Fax #: 1-405-717-8935 or 1-405-717-8947

This information is private and confidential.

(◆) Date: _____

(◆) DME Company _____

(◆) Address: _____

Contact Person: _____ (◆) Fax: _____

Phone: _____

(◆) Patient: _____ (◆) DOB: _____

(◆) Member: _____ (◆) Member's ID: _____

(◆) Physician: _____ Phone: _____

NOTE: Must include Physician's signed documentation of medical necessity in order to complete review (i.e., Letter of Medical Necessity and/or Script).

Diagnosis and Summary of Care: _____

(◆) DME Description (Include HCPC Codes): _____

Rental Yes No Purchase Yes No

NOTE: Any changes or additional services require updated information.

(◆) Initial Date of Service and/or Date of Equipment Reviewed By: _____

Delivery (Required): _____ Date: _____

Secondary Date of Service: _____ Reviewed By: _____

Date: _____

*****FOR HCMD USE ONLY – DO NOT WRITE BELOW THIS LINE*****

COMMENTS: _____

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.

MEDICARE PATIENTS

If the Employees Group Insurance Program is supplemental, all services requested must be approved by Medicare.

(◆) DENOTES INFORMATION REQUIRED TO COMPLETE REVIEW FOR CERTIFICATION