

# HEALTHCHOICE

## INFUSION THERAPY REQUEST

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

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

This Information is private and confidential.

Date: \_\_\_\_\_

Infusion Therapy Agency \_\_\_\_\_

Network

Address \_\_\_\_\_

Non-Network

Contact Person \_\_\_\_\_

Phone \_\_\_\_\_ FAX # \_\_\_\_\_

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

Patient \_\_\_\_\_ DOB \_\_\_\_\_

Member's Name \_\_\_\_\_ Member's ID# \_\_\_\_\_

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

\_\_\_\_\_

Physician's Name \_\_\_\_\_

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

\_\_\_\_\_

**NOTE: Please fax initial evaluation. An extension of services requires telephone update. If any visits are not certified, visits are subject to retro-review and 10% penalty (medical records must be provided).**

Start Date \_\_\_\_\_ End Date \_\_\_\_\_ Approved \_\_\_\_\_ Date \_\_\_\_\_

Extension #1 \_\_\_\_\_ End Date \_\_\_\_\_ Approved \_\_\_\_\_ Date \_\_\_\_\_

Extension #2 \_\_\_\_\_ End Date \_\_\_\_\_ Approved \_\_\_\_\_ Date \_\_\_\_\_

Extension #3 \_\_\_\_\_ End Date \_\_\_\_\_ Approved \_\_\_\_\_ Date \_\_\_\_\_

\*\*\*\*\* **FOR HCMD USE ONLY (Do Not Write Below This Line)** \*\*\*\*\*

### 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.

**MEDICARE PATIENTS:** If the Employees Group Insurance Program is supplement, all services requested must be approved by Medicare.

**TO ASSURE PAYMENT --- ATTACH REFERRAL TO CLAIM FORM**