HEALTHCHOICE

Medication/Treatment Request

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

Fax # 1-405-717-8947

Date: ____________________

Provider: ____________________

Address: ____________________

Network ☐ Non-Network ☐

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:

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

Start Date: ______________ End 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. December, 2008