

HEALTHCHOICE

OUTPATIENT CHEMICAL DEPENDENCY REFERRAL

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

Fax # 1-405-717-8704

This Information is private and confidential.

Date: _____

Provider _____

Network

Address _____

Non-network

Contact Person _____

Phone _____

Fax _____

Patient _____

DOB _____

Member's Name _____

Member's ID# _____

DSM IV Diagnosis

Axis I _____

Axis II _____

Axis III _____

Axis IV (List Stressors) _____

Axis V _____

Medications

Brief History of Substance Abuse

History of Previous Chemical Dependency/Psychiatric Treatment

Current Status of Patient

Treatment Goals

Progress In Treatment

What community resources have been considered? EAP Involvement?

Describe the proposed treatment and why you consider it to be medically necessary at this time:

Number of Session Requested _____ Beginning Date of Additional Sessions _____
With End Date Of _____

Signature

NOTE: Please FAX Initial Evaluation. An extension of services requires telephone update.

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

Start Date	_____	End Date	_____	Approved By	_____	Date	_____
Extension #1	_____	End Date	_____	Approved By	_____	Date	_____
Extension #2	_____	End Date	_____	Approved By	_____	Date	_____
Extension #3	_____	End Date	_____	Approved By	_____	Date	_____

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 supplement, all services requested must be approved by Medicare.

TO ASSURE PAYMENT --- ATTACH REFERRAL TO CLAIM FORM