



# GlobalHealth

## PHYSICIAN TREATMENT REQUEST FORM

Fax all clinical documentation along with the request form to: 405-280-5398. Contracted providers should use their HealthAxis Provider Portal

**Urgent Request**  **Routine Request**  **Additional Documentation**

Patient Name: \_\_\_\_\_

Member ID #: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_\_

PCP: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Treatment Description: \_\_\_\_\_

\_\_\_\_\_

Diagnosis Code(s): \_\_\_\_\_

\_\_\_\_\_

Estimated Length of Treatment: \_\_\_\_\_

Date Span of treatment or number of Cycles: \_\_\_\_\_

\_\_\_\_\_

### Type of Service Requested

- Chemotherapy
- Diagnostic Procedure
- Dialysis
- DME
- Infusion
- Inpatient Admission
- Lab
- Observation
- Occupational Therapy
- Office Visit
- Outpatient Surgery
- Physical Therapy
- Speech Therapy

Ordering Provider: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

NPI: \_\_\_\_\_

Requested Provider: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

NPI: \_\_\_\_\_

Requested Facility: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

NPI: \_\_\_\_\_

**Please complete grid below or attach detailed treatment plan along with any clinical information.**

Line	CPT, ICD or HCPCS Codes	Modifier	Description	Total Units
1.				
2.				
3.				
4.				
5.				