



PHYSICIAN TREATMENT REQUEST FORM
 Fax to: 405-609-6370 or 866-609-6370

Patient Name _____	Medical Record # _____
Member ID # _____	Date of Birth ___/___/___
Place of Residence (<i>Circle One</i>): Home LTC Assisted Living	
PCP _____	Phone # _____
Fax# _____	Physician's Signature _____

Type of Service Requested (<i>Circle One</i>):			
Consult	OB Care	Consult & Treatment	
MRI/CT Scan	DME	Surgery	Injectable Medication
(<i>Circle One</i>): URGENT ROUTINE SERVICE REQUESTED BY PATIENT			

Physician/Provider/Facility Requested _____	
Provider Phone # _____	Provider Fax # _____
Date of Care (If Known): _____	
Please submit any clinical notes, test results, etc, to support this request and expedite the referral process	

ICD9CM Code(s) _____	CPT Codes _____
Symptoms _____	Duration _____
Relevant Labs _____	Diagnostic Test Results _____
Number of Visits Requested _____	Date Span _____

<u>Tried and/or Failed Treatment (Consider Guidelines)</u>		

<u>Patient Compliance with Treatment</u>		

Date of Last Visit ___/___/___	Height _____	Weight _____

<u>GlobalHealth, Inc. - Care Management Division Only:</u>			
DECISION (<i>Circle One</i>)	APPROVED	DENIED	DEFERRED
Comments _____			
Signature and Date _____			