Generations Medicare Advantage Plans
210 Park Ave. | Suite 2800 | Oklahoma City, OK 73102-5621

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

Patient Name____

Member ID #____Date of Birth_____/___/_____

PCP____

Phone #______________________________Fax # ___________________________________

Person Filling Out Form: _______________________Phone # ____________________________

CIRCLE ONE:

URGENT **ROUTINE**

Type of Service Requested (*Circle One*):

DIAGNOSTIC PROCEDURE DIALYSIS DME HOME HEALTH

INPATIENT ADMISSION LAB OBSERVATION CCUPATIONAL THERAPY

OFFICE VISIT OUTPATIENT SURGERY PHYSICAL THERAPY SPEECH THERAPY

Referred by Provider: ____

Provider Phone #: ____________________________Fax #: ______________________________

Referred to Provider: ____

Provider Phone #: ____________________________Fax #: ______________________________

And/or

Referred to Facility: ____

Address: ____

Phone #: ___________________________________Fax #: ______________________________

ICD-10 Code: ______________________________Quantity: ____________________________

ICD-10 Code: ______________________________Quantity: ____________________________

CPT Code(s): ____