



GlobalHealth

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

(***DO NOT USE IF YOU HAVE GLOBALLINK***)

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): _____