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): _____