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 SUBMITTED Through PROVIDER PORTAL*)

Patient Name____

Member ID #______________________________ Date of Birth___/___/_____

PCP____

Phone #______________________ Fax # ______________________

Person Filling Out Form: ______________________ Phone # ______________________

CIRCLE ONE:

EXPEDITED **STANDARD**

Type of Service Requested (*Circle One*):

DIAGNOSTIC PROCEDURE DIALYSIS DME HOME HEALTH

INPATIENT ADMISSION LAB OBSERVATION OCCUPATIONAL 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 #: ______________________

CPT Code(s): ______________________ Quantity: ______________________

CPT Code(s): ______________________ Quantity: ______________________

ICD-10 Code: ____