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): ____