PHYSICIAN TREATMENTREQUESTFORM

Faxall clinicaldocumentationalong with therequest form to: 405-280-5398.Contracted providers should use their HealthAxis Provider Portal

Urgent Request **Routine Request** **Additional Documentation**

Patient Name: _____

Member ID #: _____ Date of Birth: ____ /_____ / _____

PCP: _____

Phone: _____ Fax: _____

Treatment Description: _____

_____

Diagnosis Code(s): _____

_____

Estimated Length of Treatment: _____

Date Span of treatment or number of Cycles: _____

_____

Type of Service Requested

- ☐ Chemotherapy
- ☐ Diagnostic Procedure
- ☐ Dialysis
- ☐ DME
- ☐ Infusion
- ☐ Inpatient Admission
- ☐ Lab
- ☐ Observation
- ☐ Occupational Therapy
- ☐ Office Visit
- ☐ Outpatient Surgery
- ☐ Physical Therapy
- ☐ Speech Therapy

Ordering Provider: _____
Phone: _____
Fax: _____
NPI: _____

Requested Provider: _____
Phone: _____
Fax: _____
NPI: _____

Requested Facility: _____
Phone: _____
Fax: _____
NPI: _____

Please complete grid below or attach detailed treatment plan along with any clinical information.

Line	CPT, ICD or HCPCS Codes	Modifier	Description	Total Units
1.				
2.				
3.				
4.				
5.				