

HEALTHCHOICE

3545 NW 58th, Suite 500, Oklahoma City, OK 73112
Phone: 1-800-543-6044 or 1-405-717-8879
FAX: 1-405-717-8947 or 1-405-717-8935

DME REFERRAL INFORMATION

This information is private and confidential.

(◆) Billing Provider: _____ (◆) Date: _____

(◆) Billing Address: _____

(◆) TIN: _____ Contact Person: _____

Phone: _____ (◆) Fax: _____

(◆) Patient: _____ (◆) DOB: _____

(◆) Member: _____ (◆) Member's ID: _____

(◆) Physician: _____ Phone: _____

NOTE: Must include Physician's signed documentation of medical necessity in order to complete review (i.e., Letter of Medical Necessity and/or Script).

Diagnosis and Summary of Care: _____

(◆) DME Description (Include HCPC Codes): _____

Rental Yes No Purchase Yes No

NOTE: Any changes or additional services require updated information.

(◆) Date of Service being requested (for rental item) or Date of _____ Secondary Date of Service; _____
equipment delivery for purchase item: _____

*****FOR HCMD USE ONLY – DO NOT WRITE BELOW THIS LINE*****

CERT MET / PENALTY APPLIES

Reviewed By: _____

Date: _____

CERT MET / PENALTY APPLIES

Reviewed By: _____

Date: _____

COMMENTS: _____

NOTE: These benefits are applicable only if the patient is eligible for HealthChoice, and are subject to ALL POLICY PROVISIONS. Please remember to verify benefits and eligibility by calling 1 (800) 782-5218.

MEDICARE PATIENTS: If HealthChoice is supplement, all services requested must initially be approved by Medicare.

(◆) DENOTES INFORMATION REQUIRED TO COMPLETE REVIEW FOR CERTIFICATION