

HEALTHCHOICE

3545 N.W. 58th St., Ste. 500, Oklahoma City, OK 73112
Phone: 1-405-717-8879 or toll-free 1-800-543-6044
FAX: 1-405-717-8947 or 1-405-717-8935

DME REFERRAL INFORMATION

This form must be completed and accompany all requests. Incomplete forms will not be reviewed.

Billing Provider: _____ Date: _____
Billing Address: _____
TIN: _____ Contact Person: _____
Contact Phone #: _____ Fax #: _____
Patient: _____ DOB: _____
Primary Member: _____ Member ID #: _____
Physician: _____ Phone: _____

NOTE: Must include physician's signed documentation of medical necessity in order to complete review (i.e., letter of medical necessity, CMN and/or script).

ICD code and summary of care:

HCPC code(s) must include descriptions for all miscellaneous codes:

Rental: Yes No Purchase: Yes No

NOTE: Any changes or additional services require updated information.

Date(s) of Service being requested: _____ If the date of service has already occurred, it must be included to complete review.

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

Reviewed By: _____ Reviewed By: _____

Date: _____ 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 1-405-416-1800 or toll free 1-800-782-5218 prior to submitting this request.

MEDICARE PATIENTS: If HealthChoice provides coverage that is a supplemental to Medicare, all requested services must first be approved by Medicare and Medicare explanation of benefits filed with the claim for processing.

****All information on this form is required for review. Information provided is private and confidential.****