

# HEALTHCHOICE

3545 NW 58<sup>th</sup> 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

## HOME HEALTH REQUEST

**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: \_\_\_\_\_

Member: \_\_\_\_\_ Member ID #: \_\_\_\_\_

ICD Code(s): \_\_\_\_\_ HCPCS Code(s): \_\_\_\_\_

CPT Code(s): \_\_\_\_\_

Physician's Name: \_\_\_\_\_

485 Provided? YES  NO

### #1) The most recent clinical note must accompany your request:

PLEASE LIST TOTAL # OF SERVICES AND FREQUENCY REQUESTED FOR EACH SPECIALTY (EX: 1 W 1, 2 W 2)

SNV \_\_\_\_\_ Frequency: \_\_\_\_W\_\_\_\_, \_\_\_\_W\_\_\_\_ PT \_\_\_\_\_ Frequency: \_\_\_\_W\_\_\_\_, \_\_\_\_W\_\_\_\_

OT \_\_\_\_\_ Frequency: \_\_\_\_W\_\_\_\_, \_\_\_\_W\_\_\_\_ ST \_\_\_\_\_ Frequency: \_\_\_\_W\_\_\_\_, \_\_\_\_W\_\_\_\_

START DATE \_\_\_\_\_ ENDING DATE \_\_\_\_\_

### #2) The most recent clinical notes must accompany your request:

PLEASE LIST TOTAL # OF SERVICES AND FREQUENCY REQUESTED FOR EACH SPECIALTY (EX: 1 W 1, 2 W 2)

SNV \_\_\_\_\_ Frequency: \_\_\_\_W\_\_\_\_, \_\_\_\_W\_\_\_\_ PT \_\_\_\_\_ Frequency: \_\_\_\_W\_\_\_\_, \_\_\_\_W\_\_\_\_

OT \_\_\_\_\_ Frequency: \_\_\_\_W\_\_\_\_, \_\_\_\_W\_\_\_\_ ST \_\_\_\_\_ Frequency: \_\_\_\_W\_\_\_\_, \_\_\_\_W\_\_\_\_

START DATE \_\_\_\_\_ ENDING DATE \_\_\_\_\_

### #3) The most recent clinical notes must accompany your request:

PLEASE LIST TOTAL # OF SERVICES AND FREQUENCY REQUESTED FOR EACH SPECIALTY (EX: 1 W 1, 2 W 2)

SNV \_\_\_\_\_ Frequency: \_\_\_\_W\_\_\_\_, \_\_\_\_W\_\_\_\_ PT \_\_\_\_\_ Frequency: \_\_\_\_W\_\_\_\_, \_\_\_\_W\_\_\_\_

OT \_\_\_\_\_ Frequency: \_\_\_\_W\_\_\_\_, \_\_\_\_W\_\_\_\_ ST \_\_\_\_\_ Frequency: \_\_\_\_W\_\_\_\_, \_\_\_\_W\_\_\_\_

START DATE \_\_\_\_\_ ENDING DATE \_\_\_\_\_

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

**NOTE:** These benefits are applicable only if the patient is an eligible enrolled member of a HealthChoice plan. All benefits are subject to the deductible, coinsurance and policy provisions. Please verify benefits and eligibility by calling the medical claims administrator at 1-405-416-1800 or toll-free 1-800-782-5218.

**Medicare Patients:** If HealthChoice is the supplement insurance carrier, authorization from HealthChoice is not required. Please contact Medicare.