

Medical Records

Scan Sheet

This scan sheet is required to match submitted medical records to the correct claim. Complete a scan sheet for each claim for which you are submitting medical records. **Medical records received without a scan sheet will be returned to the provider.**

Please use black ink when completing this form.

Today's Date (mm/dd/yyyy)

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Member	<p>2 First Name <input style="width: 100%; height: 20px;" type="text"/></p> <p>Last Name <input style="width: 100%; height: 20px;" type="text"/></p> <p>3 Member ID# Or Member Social Security Number <input style="width: 150px; height: 20px;" type="text"/></p>
Patient	<p>4 Same as member <input type="checkbox"/> If not, provide patient first and last name below.</p> <p>5 First Name <input style="width: 100%; height: 20px;" type="text"/></p> <p>Last Name <input style="width: 100%; height: 20px;" type="text"/></p>
Claim	<p>6 Claim # <input style="width: 100%; height: 20px;" type="text"/></p> <p>8 Date of Service (mm/dd/yyyy) <input style="width: 150px; height: 20px;" type="text"/></p> <p style="text-align: right;">7 Claim Type</p> <p style="text-align: right;">HealthChoice <input type="checkbox"/></p> <p style="text-align: right;">Department of Corrections <input type="checkbox"/></p> <p style="text-align: right;">Department of Rehabilitation Services <input type="checkbox"/></p>
Provider	<p>9 Provider Name <input style="width: 100%; height: 20px;" type="text"/></p> <p>10 Provider NPI # <input style="width: 100%; height: 20px;" type="text"/></p>

If you have questions on how to fill out this scan sheet please contact customer service at 405-416-1800 or 800-782-5218.

Send completed scan sheets and medical records to P.O. Box 24870, OKC, OK 73124.