

# HEALTHCHOICE

## OSTEOPATHIC PHYSICAL MEDICINE TREATMENT INFORMATION

3545 NW 58th Street, Suite 500 -- Oklahoma City, Oklahoma 73112

Phone 1-800-543-6044 or 1-405-717-8879

Fax # 1-405-717-8935 or 1-405-717-8947

**This Information is private and confidential.**

Date: \_\_\_\_\_

Physician \_\_\_\_\_

Address \_\_\_\_\_

Contact Person \_\_\_\_\_

Phone \_\_\_\_\_

Fax # \_\_\_\_\_

Patient \_\_\_\_\_

DOB \_\_\_\_\_

Member's Name \_\_\_\_\_

Member's ID# \_\_\_\_\_

Diagnosis & Summary of Care \_\_\_\_\_

Original Short/Long Term Goals \_\_\_\_\_

New Goals \_\_\_\_\_

### EVALUATION DATES

### TREATMENTS

Initial Evaluation \_\_\_\_\_

Total Treatments to Date \_\_\_\_\_

2nd Evaluation \_\_\_\_\_

Number (#) of Additional Tx's Being Requested \_\_\_\_\_

3rd Evaluation \_\_\_\_\_

Frequency of Treatments Begin Requested \_\_\_\_\_

Beginning Date for Additional Treatments \_\_\_\_\_

Ending Date for Additional Treatments \_\_\_\_\_

\*\*\*\*\* **FOR HCMD USE ONLY (Do Not Write Below This Line)** \*\*\*\*\*

Extension #1      Circle One    APPROVED    DENIED    Reviewer \_\_\_\_\_      Date \_\_\_\_\_

# of Treatments Approved      Start Date \_\_\_\_\_      Ending Date \_\_\_\_\_

Extension #2      Circle One    APPROVED    DENIED    Reviewer \_\_\_\_\_      Date \_\_\_\_\_

# of Treatments Approved      Start Date \_\_\_\_\_      Ending Date \_\_\_\_\_

COMMENTS \_\_\_\_\_

These benefits are applicable only if the patient is eligible for the Employees Group Insurance program and are subject to **ALL POLICY PROVISIONS**. Please remember to verify benefits and eligibility by calling 1-800-782-5218.

**MEDICARE PATIENTS:** If the Employees Group Insurance Program is supplement, all services requested must be approved by Medicare. Rev. April, 2008