

HEALTHCHOICE

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

SPEECH THERAPY REQUEST

This form must be completed and accompany each request. Incomplete forms will not be reviewed.

Billing Provider: _____ Date: _____

Billing Address: _____

TIN: _____ Contact Person: _____

Contact Phone #: _____ Fax #: _____

Referring Physician: _____

Patient: _____ DOB: _____

Primary Member: _____ Member ID #: _____

Communicative Diagnosis ICD 10 Code: _____ Date of Onset: _____

OR

Autism Spectrum Disorder ICD 10 Diagnosis Code: _____ Date Diagnosed: _____

Name of MD, DO or Doctor of Psychology diagnosing Autism Spectrum Disorder: _____

CPT Code(s): _____

Summary Progress Towards Current ST Goals: _____

New ST Goals: _____

TREATMENTS

Initial Evaluation Date: _____ Total Treatments to Date: _____

2nd Evaluation Date: _____ 3rd Evaluation Date: _____

Request for Additional Treatments

Number of Treatments: _____ Frequency of Treatments: _____

Dates for Additional Treatments – Beginning Date: _____ Ending Date: _____

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

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

Medicare Patients: If HealthChoice is the Medicare supplement insurance, no HealthChoice authorization is required. Please contact Medicare.