GlobalHealth

701 N.E. 10th St., Suite 300, Oklahoma City, OK 73104-5403

PHYSICIAN TREATMENT REQUEST FORM

Fax ALL clinical documentation along with the request form to: 405-280-5398

(*DO NOT USE IF YOU HAVE GLOBALLINK*)

Patient Name____

Member ID #______________________________ Date of Birth___/___/_____

PCP____

Phone #______________________ Fax # ______________________

Person Filling Out Form: __________________ Phone # __________________

CIRCLE ONE:

URGENT **ROUTINE**

Type of Service Requested (*Circle One*):

DIAGNOSTIC PROCEDURE DIALYSIS DME HOME HEALTH

INPATIENT ADMISSION LAB OBSERVATION CCUPATIONAL THERAPY

OFFICE VISIT OUTPATIENT SURGERY PHYSICAL THERAPY SPEECH THERAPY

Referred by Provider: ____________________________________

Provider Phone #: __________________ Fax #: __________________

Referred to Provider: ____________________________________

Provider Phone #: __________________ Fax #: __________________

And/or

Referred to Facility: ____________________________________

Address: ____________________________________

Phone #: __________________ Fax #: __________________

ICD-10 Code: __________________ Quantity: __________________

ICD-10 Code: __________________ Quantity: __________________

CPT Code(s): ____________________________________

UPDATE 3/2017