



210 Park Ave. | Suite 2800 | Oklahoma City, OK 73102-5621

**PHYSICIAN TREATMENT REQUEST FORM**

Fax **ALL** clinical documentation along with the request form to: 405-280-5398  
(\* DO NOT USE IF SUBMITTED Through PROVIDER PORTAL\*)

Patient Name \_\_\_\_\_

Member ID # \_\_\_\_\_ Date of Birth \_\_\_/\_\_\_/\_\_\_

PCP \_\_\_\_\_

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

Person Filling Out Form: \_\_\_\_\_ Phone # \_\_\_\_\_

**CIRCLE ONE:**

**EXPEDITED                      STANDARD**

Type of Service Requested (*Circle One*):

- |                      |                    |                  |                      |
|----------------------|--------------------|------------------|----------------------|
| DIAGNOSTIC PROCEDURE | DIALYSIS           | DME              | HOME HEALTH          |
| INPATIENT ADMISSION  | LAB                | OBSERVATION      | OCCUPATIONAL THERAPY |
| OFFICE VISIT         | OUTPATIENT SURGERY | PHYSICAL THERAPY | SPEECH THERAPY       |

Referred by Provider: \_\_\_\_\_

Provider Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

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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): \_\_\_\_\_