



# HealthChoice

2401 N. Lincoln Blvd., Ste. 300, Oklahoma City, OK 73105  
Phone: 405-717-8879 or 800-543-6044, ext. 8879  
Fax: 405-949-5459 or 405-949-5501

## DME REFERRAL INFORMATION

**This form must be completed and accompany all requests. Incomplete forms will not be reviewed.**

Billing provider \_\_\_\_\_ Date \_\_\_\_\_

Billing address \_\_\_\_\_

TIN \_\_\_\_\_ Contact person \_\_\_\_\_

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

Patient \_\_\_\_\_ DOB \_\_\_\_\_

Member \_\_\_\_\_ Member ID \_\_\_\_\_

Physician \_\_\_\_\_ Phone \_\_\_\_\_

**NOTE:** Must include physician's signed documentation of medical necessity in order to complete review (i.e., letter of medical necessity, CMN and/or script)

ICD code and summary of care

\_\_\_\_\_  
\_\_\_\_\_

HCPC code(s) must include descriptions for all miscellaneous codes

\_\_\_\_\_  
\_\_\_\_\_

**Rental:** Yes  No

**Purchase:** Yes  No

**NOTE:** Any changes or additional services require updated information.

Date(s) of service being requested: \_\_\_\_\_ If the date of service has already occurred, it must be included to complete review.

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

**NOTE:** These benefits are applicable only if the patient is an eligible enrolled member of a HealthChoice plan. All benefits are subject to the deductible, coinsurance and policy provisions. Please verify benefits and eligibility by calling the medical claims administrator toll-free at 800-323-4314.

**MEDICARE PATIENTS:** If HealthChoice is the supplemental insurance carrier, authorization from HealthChoice is not required. Please contact Medicare.

\*\*\*\*\* **FOR HCMU USE ONLY – DO NOT WRITE BELOW THIS LINE** \*\*\*\*\*

Reviewed by \_\_\_\_\_

Reviewed by \_\_\_\_\_

Date \_\_\_\_\_

Date \_\_\_\_\_

Comments

\_\_\_\_\_