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

SPEECH THERAPY REQUEST

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 _____

Referring physician _____

Patient _____ DOB _____

Member _____ Member ID _____

Communicative diagnosis ICD 10 code _____ Date of onset _____

CPT code(s) _____

OR

Autism Spectrum Disorder ICD 10 diagnosis code _____ Date diagnosed _____

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

Summary progress toward 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: 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.