

## SoonerCare Lodging and/or Meals Request

### **Referring Contact**

Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_

### **Member**

Name: \_\_\_\_\_ SoonerCare ID# \_\_\_\_\_

Address: \_\_\_\_\_

Contact Name: \_\_\_\_\_ Contact Number: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

**Visit Information** \_\_\_\_\_ Inpatient \_\_\_\_\_ Outpatient (Select all that apply)

Facility Name: \_\_\_\_\_

Provider Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Appointment Date: \_\_\_\_\_ Time: \_\_\_\_\_ Check-In Time: \_\_\_\_\_ Duration: \_\_\_\_\_

Admit Date: \_\_\_\_\_ Time: \_\_\_\_\_ Check-In Time: \_\_\_\_\_ Length of Stay: \_\_\_\_\_

Reason for Visit: \_\_\_\_\_

Is Service Trial or Experimental? \_\_\_\_\_

**Services Requested** (Select which services are being requested)

\_\_\_\_ Meals \_\_\_\_ Lodging

Requested Lodging Provider: \_\_\_\_\_

### **Escort**

Name: \_\_\_\_\_ Relationship to Member: \_\_\_\_\_

Medical Necessity for Escort: \_\_\_\_\_

Additional Comments: \_\_\_\_\_

Please attest to the appointment/admit times and dates with all providers for this request:

(Signature) \_\_\_\_\_

**Send form to: OHCA - Population Care Management Division. Fax: 405-530-3217**

*\*To expedite the process, please include medical records and/or a letter of medical necessity.*

Date: \_\_\_\_\_

HCA-64