



701 NE 10th ST | Ste. 300 | Oklahoma City, OK | 73104-5403

PHYSICIAN TREATMENT REQUEST FORM
Fax to: 405-280-5398

Patient Name _____	Medical Record # _____
Member ID # _____	Date of Birth ____/____/____
Place of Residence (<i>Circle One</i>): Home	LTC Assisted Living
PCP _____	Phone # _____
Fax# _____	Physician's Signature _____

Type of Service Requested (*Circle One*):

Consult	OB Care	Consult & Treatment
MRI/CT Scan	DME	Surgery
		Injectable Medication
(<i>Circle One</i>): URGENT ROUTINE SERVICE REQUESTED BY PATIENT		

Physician/Provider/Facility Requested _____

Provider Phone # _____ **Provider Fax #** _____

Date of Care (If Known): _____

*****Please submit any clinical notes, test results, etc, to support this request and expedite the referral process*****

ICD9CM Code(s) _____	CPT Codes _____
Symptoms _____	Duration _____
Relevant Labs _____	Diagnostic Test Results _____
Number of Visits Requested _____	Date Span _____

Tried and/or Failed Treatment (Consider Guidelines)

Patient Compliance with Treatment

Date of Last Visit ____/____/____ **Height** _____ **Weight** _____

GlobalHealth, Inc. - Care Management Division Only:

DECISION (Circle One) **APPROVED** **DENIED** **DEFERRED**

Comments _____

Signature and Date _____