SoonerCare
Oklahoma Health Care Authority

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*