REQUEST FOR NEW SOONERCARE COVERAGE CONSIDERATION FORM

RCI REQUEST FORM

FORM INFORMATION BELOW:

Contact information			
Name:		Number:	
Email:			

Title and company
Please include manufacturer's name,if different from company name:

Name of device, drug/biologic or procedure

Please list any other similar devices, drugs/biologicals or procedures that are currently covered by Medicaid

CPT or HCPCS code	
Please include code description:	

Diagnosis/diagnoses and condition(s) for which this service is medically necessary

Provide a brief description of the device, treatment or procedure, including desired or expected outcomes *(i.e., increased survival, decreased need for hospitalization)*

ADDRESS
4345 N. Lincoln Blvd.
Oklahoma City, OK 73105

WEBSITES
oklahoma.gov/OHCA
mysoonercare.org

PHONE
Admin: 405-522-7300
Helpline: 800-987-7767

OKLAHOMA
Health Care Authority

Provide details regarding the patient population whose quality of care will be improved due to this request

Has this service received FDA approval? If yes, for which diagnoses has the service been FDA-approved? Please include the approval as an attachment.

Has this service received any other approval? If yes, please include the approval as an attachment.

If the requested service is a diagnostic test, is this testing medically necessary prior to a covered FDA approved treatment? If yes, please explain fully and attach any supporting documents.

Are there nationally recognized clinical practice guidelines and/or professional society consensus statements that support medical necessity for this service? If yes, please include as an attachment.

Cost of the device, drug/biologic or procedure *(i.e., per use, annual, lifetime)*

Does the medical literature on this device, drug/biologic or procedure demonstrate likelihood for cost savings to the Medicaid program? If yes, please explain and cite.

Include any Centers for Medicare and Medicaid Services (CMS) National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs) or Medicare Administrative Contractor (MAC) local coverage determinations, along with the date issued

If known, provide the private insurers that reimburse for this device, drug/biologic or procedure

Is coverage supported by other state Medicaid programs? List states or entity, if known.

If you are a provider, are you currently using/performing this service in your practice? If yes, please supply information regarding improved outcomes for your patients.

If you are a vendor, are you requesting coverage due to requests by SoonerCare contracted providers? If yes, please supply their contact information and attach any supporting documentation from their requests.

Completed forms can be sent to **massunit@okhca.org**.

OHCA Revised 12/26/2023