



Date: _____
Case name: _____
Case number: _____
County number: _____
Supervisor/worker number: __ / __

Notification of Needed Medical Services

Section I - Patient identification.

Last name		Middle	First	OKDHS case number	
Date of birth	Sex	Race	Social Security number (SSN)		Phone
Name of parent or guardian		Parent's SSN (optional)		Parent's date of birth (optional)	
Street or P.O. Box mailing address			City	State	Zip
Physician			Physician's address		
Other medical provider			Other medical provider's address		

Section II - Inpatient services.

Admitting diagnosis	Admitting date
Discharge recommendations	Discharge date

This is to notify that the above-named individual was admitted to the hospital at the request of his or her attending physician. It is our intention to file a claim with the Oklahoma Health Care Authority (OHCA) for payment for this period of hospitalization if claim is compensable. Please advise us of his or her OKDHS case number and information concerning his or her current eligibility status for medical care or any other information pertinent for our use in preparing a claim to be filed in behalf of said recipient. Records and information pertaining to his or her hospitalization will be made available to OHCA or OKDHS, or any representative authorized by OHCA, for the purpose of determining compensability of claims on his or her behalf.

Signature of administrator or designee	Provider number	Date
Name of facility	Address of facility	
Signature of attending physician	Physician provider number	Date

Section III - Outpatient care or other services.

Written diagnosis	Admitting date
Recommended treatment related to diagnosis	
Frequency, length, and duration of treatment	Beginning date of service

Is the above-written diagnosis the result of an accident or occupational disease? Yes No Unknown

Records and information pertaining to these services will be made available to OHCA or OKDHS, or any representative authorized by OHCA for the purpose of determining compensability of claims in the patient's behalf.

Signature of physician	Physician provider number	Date
------------------------	---------------------------	------

Section IV - Other provider of recommended treatment.

Signature and title of recommended provider	Physician provider number	Date
---	---------------------------	------

Address

Purpose of form

Form 08MA005E (MS-MA-5) is used by providers of medical services to notify the local OKDHS human services center (HSC) of needed in-patient medical services, outpatient care, or other services for an adult or child. It serves also as notice of the provider's intention to file a claim for payment for the service. This form is also used for services that require prior authorization through OHCA.

Routing

If Form 08MA005E (MS-MA-5) is used for services that require prior authorization through the OHCA, the recommended provider submits the original Form 08MA005E (MS-MA-5) and required assessments/evaluations to:

Oklahoma Health Care Authority
2401 NW 23rd St., Suite 1-A
Oklahoma City, OK 73107

If determining eligibility, this form is sent or faxed to the local OKDHS HSC in the county of the patient's residence.