Out of Network Provider Request Form

Patient Information:	Patient Name:	
	Address:	
	City:	State:
	Zip:	
	Telephone:	Cell#:
	Chief Complaint, Diagnoses and Body Parts:	

Treating Provider Information:	Provider Name:	
	Tax ID:	NPI:
	Telephone:	Fax:
	Address:	
	City:	State:
	Zip Code:	Specialty:

Referred Out of Network Provider Information:	Provider Name:	
	Tax ID:	NPI:
	Telephone:	Fax:
	Address:	
	City:	State:
	Zip Code:	Specialty:

Out of Network Referral Reasoning:	

Out of Network Provider Request Form

Requested Referred Services:	

Start Date of Requested Services:	**End Date of Requested Services:**

Required Information: Please attach all medical documentation including Statement of Medical Necessity, medical notes and any additional information needed to provide our Texas HCN of the necessity of the services requested.

Contact **Prime Health Services, Inc.** for further assistance at **1 (866) 348-3887**
Please email **completed** forms to Prime Health Provider Relations Department at
provider.relations@primehealthservices.com