

## Out of Network Provider Request Form

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

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

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

<b>Out of Network Referral Reasoning:</b>	
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## Out of Network Provider Request Form

<b>Requested Referred Services:</b>	
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<b>Start Date of Requested Services:</b>	<b>End Date of Requested Services:</b>
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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](mailto:provider.relations@primehealthservices.com)**