



Norman Physician Hospital Organization  
 950 N. Porter Ave. Suite 103  
 Norman, OK, 73070  
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 Fax: (405) 447-3850

**NPHO Care Coordination Appeals Form**

It is understood that the Employer retains full and final authority and responsibility for its Self-funded employee medical plan and its operation. The purpose of this form is to request a reconsideration of a denied referral request for members enrolled into the Care Coordination Benefit Plan. Please complete the form in its entirety and return to the Care Coordination office for further evaluation.

**Be Sure to Include:**

- 1. Completed Appeals Form**
- 2. Original Referral Request**
- 3. Any Supplementary Documentation that Supports the Medical Necessity of Services Needed**

<b>Employer Name:</b>	<b>Referring Physician Name/Tax ID #:</b>
<b>Employer Group Number:</b>	<b>Referring Office Phone:</b>
<b>Employee/Dependent Name</b>	<b>Referring Office Fax:</b>
<b>Employee ID:</b>	

Please present clinical information that supports the medical necessity of the services needed in the space below. List only 1 appeal per form, and if additional space is needed provide attached documentation. Full review of the appeal request may include peer-to-peer counseling between the Care Coordination Medical Director and the referring provider. You will receive a decision within 5-7 business days and all decision post appeal will be final:

Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_