



Norman Physician Hospital Organization  
 950 N. Porter Ave. Suite 103  
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**NPHO Care Coordination  
 Provider Referral 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 document the necessity for specialized services to be paid at a higher benefit level when unavailable in the applicable PPO or Domestic Network. Please complete form and return to NPHO Care Coordination office for review.

Employer Name:	Referring Physician Name/Tax ID #:
Employer Group Number:	Referring Office Phone:
Employee Name:	Referring Office Fax:
Patient Name:	

Description of Services/Procedures:

Provider(s) of Service(s):

Specialty:

Benefit Level that claims are to be paid at (circle or check one):

Tier One (Domestic)

Tier Two (PPO)

Time Frame for initial coverage: From:

To:

Additional Comments:

Signature:

Date:

**Benefits or eligibility quoted are not a guarantee of payment. All services are subject to eligibility, plan provisions and medical necessity in effect on the date services are rendered.**

**NPHO Care Coordination Office Use Only**

Care Coordinator Assigned to Case: \_\_\_\_\_

Approved By: \_\_\_\_\_ Date: \_\_\_\_\_

Date Submitted to WebTPA: \_\_\_\_\_

Denied: \_\_\_\_\_

Reason Cited: \_\_\_\_\_