



Norman Physician Hospital Organization
950 N. Porter Ave. Suite 103
Norman, OK 73070
Phone: (405) 515-6746
Fax: (405) 447-3850

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/Dependent Name:	Referring Office Fax:
Employee ID:	

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: _____ Received By: _____