NHealth
Norman Regional Health System

Phone: (405) 515-6746
Fax: (405) 515-5043

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 NRHS Care Coordination office for review.

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

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.

Care Coordination Office Use Only

Care Coordinator Assigned to Case: _____
Approved By: _____ Date: _____
Date Submitted to WebTPA: _____

Denied: _____
Reason Cited: _____