

Service Availability Form

EMPLOYER NAME: _____

If a necessary medical service is not available in your PPO network, please complete this form and send it to:

CareFirst Administrators
PO Box 3900
Merrifield, VA 22116-3900

*** Denotes a required field. Incomplete forms will not be honored.**

Employee Name (Please Print) * _____

Employee ID Number * _____

Patient Name * _____

PPO Name * _____

Service Required * _____

Specialist Required * _____

Provider Name * _____

I, _____, * hereby certify that I have checked the PPO directory and called
(Enter Name)
the PPO to determine if an In-Network provider is available within 25 miles of my home for the service I
need. After checking BOTH sources, I have determined that (check the situation that applies):

Must check one *

_____ a specialist of the type I need is not part of the PPO Network.

OR

_____ an In-Network provider is more than 25 miles from my home.

PPO Representative I spoke with _____ *

PPO Phone # _____ *

Employee signature _____ *

Date _____ *

You will need to send an updated form every 6 months.