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 14115
Lexington, KY 40512-4115

All fields required. Incomplete forms will not be honored. Updated forms required every 6 months.

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 my medical plan benefit summary*
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 the miles from my home, per my medical plan benefit summary.

PPO Representative I spoke with_____

PPO Phone #_____

Employee signature_____

Date_____

*Please review your medical plan benefit summary for the mile radius an In-Network provider must be available.

01/2017