NEVADA PREFERRED HEALTHCARE PROVIDERS

REQUEST FOR CPT CODE ALLOWABLES

Practice or Physician Name: _____

TIN: _____

Requested By: _____ Date: _____

Phone: _____ Fax: _____

Email: _____

CPT Codes:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
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12. _____
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18. _____
19. _____
20. _____

Allowables are subject to benefit plan provisions and member eligibility.
(refer to your contract for additional terms and conditions)

PLEASE MAIL OR FAX THE COMPLETED FORM TO:

Nevada Preferred Healthcare Providers
Attn: Provider Relations
PO Box 30007
Reno, Nevada 89520-3007
Phone: 800.776.6959
Fax: 775.352.2475