



## REQUEST FOR CPT CODE ALLOWABLES

Practice or Physician Name: \_\_\_\_\_

TIN: \_\_\_\_\_

Requested By: \_\_\_\_\_ Date: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Email: \_\_\_\_\_

### CPT Codes:

1. \_\_\_\_\_

11. \_\_\_\_\_

2. \_\_\_\_\_

12. \_\_\_\_\_

3. \_\_\_\_\_

13. \_\_\_\_\_

4. \_\_\_\_\_

14. \_\_\_\_\_

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15. \_\_\_\_\_

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16. \_\_\_\_\_

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17. \_\_\_\_\_

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18. \_\_\_\_\_

9. \_\_\_\_\_

19. \_\_\_\_\_

10. \_\_\_\_\_

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  
1510 Meadow Wood Lane  
Reno, Nevada 89502  
Phone: 800.776.6959  
Fax: 775.352.2475**