POINT COMFORT UNITED

Provider Request Form

Type: **SCA** ☐ **Global** ☐

Requester Name: _____

Email: _____ Phone: _____

Member Name: _____ Member ZIP: _____

Member ID: _____ Member DOB: _____

Program: UC ☐ URM ☐ RMA ☐

Specialty Needed: _____

Brief Medical Reasoning (signs/symptoms):

****Please obtain the email address of the person responsible for establishing agreements at the provider's office. Having this information will help to expedite your request. ****

Provider/Practice Name: _____

Contact Name: _____

Email: _____ Phone: _____

Provider Office Address: _____

City: _____ State: _____ Zip: _____

****If referred by another provider, please request a referral from the referring provider and attach to this form. Having a referral for specialty providers can assist with the SCA process. ****

Referring Provider Office Name: _____

Referring Provider Office Phone: _____

Email completed form to providers@pointcomfort.com or Fax to 317-505-1001

306 Prospect St, Ste 100 / Indianapolis / IN / 46225 / (317)210-2010 / providers@pointcomfort.com