AMERICAN HEALTH ADVANTAGE OF OKLAHOMA

Person Making Request: Date:

Phone #: Email:

PROVIDER

First Name: Last Name:

Provider Group/Facility Name:

Provider Type: Specialty:

Address:

City: State: Zip:

Phone #: Fax #:

Email:

Members / Patients associated with this Provider:

OUTCOME

Handled by: Date:

Outcome:

Notified Requestor: Yes ☐ No ☐ Date Notified:

How notified:

This form MUST be submitted with complete information. Incomplete forms CANNOT be processed.

Send completed form to Network Services: networkservices@amhealthplans.com