



SEND FORM TO:

EHP, INC
PO BOX 8737
LANCASTER, PA 17604-8737
FAX (717) 399-1693

Out of Panel Referral Form

Patient Information	Employee Information
SSN#: _____	SSN#: _____
First Name: _____	First Name: _____
Last Name: _____	Last Name: _____
Address: _____	Address: _____
City: _____	City: _____
State: _____	State: _____
Zip Code: _____	Zip Code: _____
Home Phone: _____	Home Phone: _____
Birth date: _____	Group Number: _____
	Employer: _____

Individual Submitting Referral	Provider/Facility Referred To
<input type="checkbox"/> Patient <input type="checkbox"/> Employee <input type="checkbox"/> Referred Physician <input type="checkbox"/> Referring Physician: * <input type="checkbox"/> Other: *	Name: _____ Specialty: _____ Phone #: _____ Address: _____ City: _____ State: _____ Zip Code: _____ Diagnosis: _____

Objects marked with an asterisk (*) must fill out this section

Name: _____

Phone #: _____

Relationship to Patient: _____

Signature: _____

Service: _____

Appointment

Scheduled:

Date: _____

In the section provided below include any pertinent information that would help in the decision process (attach additional sheets if necessary):

Completion of this form does not guarantee in-panel payment of benefits.