



# Service Availability Form

**EMPLOYER NAME:** \_\_\_\_\_

If a necessary medical service is not available in your PPO network, please complete this form and send it to:

NCAS  
PO Box 981608  
El Paso, TX 79998

**All fields required. Incomplete forms will not be honored. Updated forms required every 6 months.**

Employee Name (Please Print) \_\_\_\_\_

Employee ID Number \_\_\_\_\_

Patient Name \_\_\_\_\_

PPO Name \_\_\_\_\_

Service Required \_\_\_\_\_

Specialist Required \_\_\_\_\_

Provider Name \_\_\_\_\_

I, \_\_\_\_\_, **hereby** certify that I have checked the PPO directory and called  
(Enter Name)  
the PPO to determine if an In-Network provider is available within my medical plan benefit summary\*  
for the service I need. After checking BOTH sources, I have determined that (check the situation that  
applies):

**Must check one \***

\_\_\_\_\_ a specialist of the type I need is not part of the PPO Network.

**OR**

\_\_\_\_\_ an In-Network provider is more than the \_\_\_\_\_ miles from my home, per my medical plan  
benefit summary.

PPO Representative I spoke with \_\_\_\_\_

PPO Phone # \_\_\_\_\_

Employee signature \_\_\_\_\_

Date \_\_\_\_\_

\*Please review your medical plan benefit summary for the mile radius an In-Network provider must be available.