



# 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  
P.O. Box 10118  
Fairfax, VA 22038-8018

**\* Denotes a required field. Incomplete forms will not be honored.**

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 25 miles of the employee's residence 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 25 miles from the employee's residence.

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

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

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

Date \_\_\_\_\_ \*

**You will need to send an updated form every 6 months.**