REQUEST FOR ALLOWABLE CHARGES

DATE OF REQUEST: _______________

TAX ID #: ________________________________

PRACTICE/PROVIDER NAME: ____

REQUESTOR'S NAME: ___________________________ REQUESTOR'S TITLE: ___________________

PHONE #: ________________________________ FAX #: ___________________________________

Requesting Allowable Charges for the Specialty of: ____
(Please submit a separate request for each specialty.)

Below please indicate thirty (30) codes you would like to receive Allowable Charges for:

1. ________________	11. ________________	21. ________________
2. ________________	12. ________________	22. ________________
3. ________________	13. ________________	23. ________________
4. ________________	14. ________________	24. ________________
5. ________________	15. ________________	25. ________________
6. ________________	16. ________________	26. ________________
7. ________________	17. ________________	27. ________________
8. ________________	18. ________________	28. ________________
9. ________________	19. ________________	29. ________________
10. ________________	20. ________________	30. ________________

Allowable Charges being requested are for contracted rates under OneHealth. Actual reimbursement is subject to OneHealth, Client or its designee's claims processing guidelines and will be paid less applicable co-payment, co-insurance and/or deductible. Please allow up to 5 business days to receive a response.

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