Request for Designation as
Secondary Care Physician for a Health Plan Patient

Patient’s Name: ___________________________________ MRN: ______________________________

SWHP Network Physician’s
Specialist’s Name: ___________________________________ NPI: ______________________________

Specialty: ___________________________ Phone No: ___________________________

Office Contact Name: ___________________________ Phone No: ___________________________

Patient’s Diagnosis: ___________________________________

SWHP Network
Specialist’s Signature: ___________________________ Date: ___________________________

Type or Print Name: ___________________________________

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Forward to:

SWHP Network
Primary Care Physician (PCP): ___________________________ Clinic Location: ______________

Request Disposition: _____ Approved _____ Denied (Discussed with Specialist)

SWHP Network
PCP’s Signature: ___________________________ Date: ___________________________

Type or Print Name: ___________________________

Forward to: Kimberly Bales / SWHP Enrollment & Billing

Fax Number: 1-254-298-3199

Data entered by: ___________________________ Date: ___________________________