Provider Request Form

Type: SCA ☐ Global ☐

Requester Name: _____

Email: _____ Phone: _____

Member Name: _____

Member ID: _____ Member DOB: _____

Program: UC ☐ URM ☐ RMA ☐

Specialty Needed: _____

Brief Medical Reasoning (signs/symptoms):

Provider Office Name: _____

Provider Office Address: _____

City: _____ State: _____ Zip: _____

Provider Office Phone: _____

Comments:

Please request for a referral and attach to this form. Having a referral for specialty providers can assist with the SCA process.

Referring Provider Office Name: _____

Referring Provider Office Phone: _____

Email completed form to providers@pointcomfort.com or Fax to 317-505-1001

306 Prospect St, Ste 100 / Indianapolis / IN / 46225 / (317)210-2010 / providers@pointcomfort.com