To be completed by staff requesting POR

Date Requested: ___________________ POR is needed no later than: ___________________

Requestor Name: HSC/UMC Medical Staff Office  Phone #: 806-775-9290  Fax: 775-9294

Circle type of POR request: Initial  Ad Hoc  Follow-up  Quality

If Ad Hoc/Quality review is needed, please give brief description of issue:

POR request is for which network(s)? (circle all that apply) PPO/POS  HMO

Are there other providers in the same group or city who need a POR in the same month? YES  NO

If so, please combine your requests.

Provider Name & Title (MD/DO, etc.) ____________________________________________

UPIN#: ___________________  Provider #: ___________________

Specialty Code: (Circle correct specialties) PCP  SCP  PCP&SCP

Office sites: (circle site) Psychiatry Clinic  ENT  THOMPSON HALL
Family Medicine  Urology  Ophthalmology
OB/Gyn  Family Medicine  Student Health
Surgery  Orthopaedics  Internal Medicine
Neurology  Dermatology  Pediatrics
Dermatology  Internal Medicine
Pediatrics  Ophthalmology
Internal Medicine  THOMPSON HALL

To be completed by POR staff

DATE OF REVIEW ___________  TIME OF REVIEW ___________

DATE OF REVIEW ___________  TIME OF REVIEW ___________

You should receive information regarding the status of your request within two weeks of your request. NOTE: The Provider Office Review Tool/Results should be in the providers file and present at the time of the Credentialing Committee meeting.

Contact: Cristi Cline, RN, BSN  Director, Performance Improvement
806.743.4287  cristi.cline@ttuhsc.edu  fax: 806.743.2056