THE OHIO STATE UNIVERSITY
HEALTH PLAN

Fax completed form to (614) 292-2667

Peer to Peer Request Form

Patient Information:

Patient Name: _____ Date of Birth: _____

Insurance ID #: _____

Requesting Physician Information:

Physician Name: _____ Phone #: _____

Facility Information (if applicable): _____

Preferred Date and Time: _____ Alternate Date and Time: _____

Office Contact Name: _____ Phone #: _____ Fax #: _____

OSUHP will attempt to arrange the conversation at the convenience of both parties using your information listed.

Denial Information:

Reference #: _____

Denied service: _____

Additional clinical reasoning for Peer-to-Peer Request: _____

_____

_____

_____

To be completed by OSU Health Plan:

□ Peer-to-peer scheduled for the following date and time: _____

□ Request to referred to external specialty reviewer for completion.

□ Denial is not eligible for peer-to-peer due to the following reason(s): _____

_____