PREMIER PROVIDER NETWORK, INC.

PROVIDER REFERRAL FORM

Thank you for your continued participation with PPNI. In an effort to assist PPNI in developing a comprehensive network, providing for a full continuum of care, please provide the following information for each entity you commonly refer patients to. Fax your return to (713) 414-4953 Attn: Provider Relations or mail it to The Premier Provider Network, 11111 Richmond Avenue, Suite 243, Houston, Texas 77082 and we will process your referrals immediately. Should you require additional assistance please contact the Provider Relations Department at (866) 776-4872.

Referral #1

Physician Name (Last, First , MI)			Degree	
Primary Practice/Clinic Name			Specialty	
Primary Practice Address (include suite #)			City	State / Zip
Phone	Facsimile	Contact Name		

Referral #2

Physician Name (Last, First , MI)			Degree	
Primary Practice/Clinic Name			Specialty	
Primary Practice Address (include suite #)			City	State / Zip
Phone	Facsimile	Contact Name		

Referral #3

Physician Name (Last, First , MI)			Degree	
Primary Practice/Clinic Name			Specialty	
Primary Practice Address (include suite #)			City	State / Zip
Phone	Facsimile	Contact Name		

Referring Provider Information

Provider Name	Phone