First Choice Health®

Medical Management
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Nebraska Health Network (NHN) Waiver Form

This form is to be completed by providers participating in the Nebraska Health Network (NHN). The form is intended to submit a waiver request in which enrolled members of the Nebraska Health Network may request to see an Out of Network provider at In-Network Tier 2 pricing. If the request is approved, any other requests, such as prior authorization, also need to be submitted to First Choice Health. Once a decision is made, the member and provider will be notified by First Choice Health of the resulting decision. Referring provider should submit this form to casemanagement@fchn.com.

For questions, contact First Choice Health at 1-800-808-0450.

Date:	

Practitioner Information (referring provider)

Last Name:	First Name:	Middle:	Degree:
NPI:			

Specialty Information

Specialty:

Practice Information

TIN:	Organization NPI:	
Business/Practice Name:	Phone Number:	
Complete Mailing Address:		
Office/Business Manager:	Phone Number:	Email Address:

Patient Information

Last Name:		First Name:	Middle:
Birth Date:	Gender:	Group ID Number:	
Brief Medical History:			
Reason for Out of Network Request:			

Out of Network Provider Information

Last Name (include suffix; Jr, Sr, III):	First Name:	Middle:
Specialty:		
Business/Practice Name:	Phone Number:	
Complete Mailing Address:		
TIN:	NPI:	

I certify the information in this entire waiver request is complete, accurate, and current.

Provider Signature:	Date:

For Internal Use Only:

Approved ☐ Denied ☐	
Signature:	Date:
Comments:	