

## REQUEST FOR CPT CODE ALLOWABLES

GROUP NAME OR  
PHYSICIAN NAME: \_\_\_\_\_

TIN: \_\_\_\_\_

REQUESTED BY: \_\_\_\_\_

DATE: \_\_\_\_\_

FAX NUMBER OR EMAIL ADDRESS: \_\_\_\_\_

CPT Codes:

1. \_\_\_\_\_

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25. \_\_\_\_\_

Submit to Northern Nevada Provider Relations: [marissa.bennett@uhsinc.com](mailto:marissa.bennett@uhsinc.com)

Submit to Southern Nevada Provider Relations: [barbara.wolf@uhsinc.com](mailto:barbara.wolf@uhsinc.com)