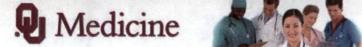
OU MEDICINE REFERRING PROVIDER INFORMATION

**MUST BE COMPLETED IN FULL **

PHYSICIAN NAME: (First)	
(First)	(Middle) (Last)
DEGREE TYPE:	(MD, DO, etc,)
DATE OF BIRTH:	
OK LICENSE NUMBER:	EXPIRATION DATE:
ADDRESS:	
CITY:	STATE: ZIP:
PHONE:()	FAX()
EMAIL:	
SPECIALTY:	NPI NUMBER:
IS PROVIDER: <u>ACTIVE</u> DUTY M VA:OR INDIAN HEALTI HE VES IN WHAT STATE IS THE DE	H:
	:
nttps://www.oumedicine.com/ou-medical-center/phy	FORM: This form is available on our website: vsicians-only Please note, our forms are take sure you use the most current form by visiting the
This section	on must be completed by
	DU MEDICINE
requesting	department personnel only:
DATE COMPLETED:	TIME COMPLETED:
REQUESTING DEPARTMENT	NAME:
	CONTACT PERSON NAME:

OU Medicine Medical Staff & Credentialing Services E-Mail OUMSCredentialing@oumedicine.com Phone: 271-3741 Fax: 271-3602

PHONE #:







OU Medicine ED and Admit/Discharge patient notifications for PCP and Referring Providers

Providers: OU Medicine now has the ability to send a de-identified text and email notification to Primary Care and Referring providers when one of their patients is seen in our ED or admitted to our facilities. Please provide a valid email and/or cell phone number and indicate which method you prefer to receive these notifications. Each message will contain a link for remote access to our EHR and our OUMC Physician Support line for any assistance you may need.

Physician Name:			
	(Please Print)		
Preferred method(s) of receiving: (Please check one)	Email	Cell	Both
Valid Email:			
(cannot b	pe a shared email account)		
Cell Phone:			
security measures in place (i.e. passwo			
Signature:		Date:	
Please scan and return to <u>OUMScreder</u>	ntialing@oumedicin	e.com	
Credentialing Questions: OU Medicine Med Staffing and Creden	tialing Office - 405-	271-5198	
Access Questions:			

OU Medicine Physician Support - 405-271-8660, Option 1, then 2

Or oumc.physiciansupport@oumedicine.com