



53842 Generation Dr * South Bend, IN 46635 * 574-647-1820 or 888-689-2242 * Fax 574-647-3947

PROVIDER REQUEST FORM

Date: _____ Employer: _____

Phone#: _____ County: _____

Employee Requesting: _____ Phone #: _____

Address: *Street* _____ *City* _____ *State* _____ *Zip* _____

Email Address: _____ County _____

PROVIDER NAME: _____ SPECIALTY: _____

Address: *Street* _____ *City* _____ *State* _____ *Zip* _____

PROVIDER PHONE NUMBER: _____

EMPLOYER USE ONLY

Date: _____ Employer Contact: _____

Employer Contact Phone Number: _____

Email Address: _____

Number of Lives: _____

Broker Name (if applicable): _____

TPA/Payor/Consultant Name (if applicable): _____

INTERNAL USE ONLY

DATE REQUEST RECEIVED: _____

TRACKING INFORMATION: _____

WAS PROVIDER CONTRACTED? Yes / No

IF YES, EFFECTIVE DATE: _____

IF NO, EXPLANATION INDICATED? _____

DATE & METHOD CLIENT NOTIFIED OF OUTCOME: _____

Provider Relations Representative: _____