COMMUNITY HEALTH ALLIANCE

3245 Health Dr., Ste 100 * Granger, IN 46530* 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: _____