



Community Health AllianceSM

3355 Douglas Rd., Suite 300 * South Bend, IN 46635 * 574-647-1820 or 888-689-2242 * Fax 574-647-1825

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: _____
NDS NAME/DATE ASSIGNED: _____
TRACKING INFORMATION: _____

WAS PROVIDER CONTRACTED? Yes / No
IF YES, EFFECTIVE DATE: _____
IF NO, EXPLANATION INDICATED?

DATE & METHOD CLIENT NOTIFIED OF OUTCOME: _____

Provider Relations Representative: _____