

LOG #: _____

Requestor Name: _____

Date: _____

Member Contact Information

Name:	
Address:	
City, State, Zip Code:	
County:	
Member ID#:	

Prospective Provider Information

Name <i>(First, MI, Last)</i> :	
NPI/ Tax ID Numbers:	
Group Name:	
Provider Type:	
Address:	
City, State, Zip Code:	
County:	
Phone Number:	
Email Address:	

Question/Issue: *(Please provide sufficient details to allow for research/resolution; include dates, times, Member ID# and other information as necessary).*

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Manager Reviewed: _____

Date: _____

PROVIDER NETWORK USE ONLY

Reviewed By: _____

Date: _____

Findings and Actions Taken:

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Date Closed and Returned to Submitter: _____