HEALTH WEST PROVIDER REQUEST FORM

(If you need to add additional providers, please send a second form)

Employee Name: _____

Employee City, State, Zip: _____

Employee Phone #: _____E-mail: _____

Request #1:

Clinic/Practice or Facility Name: _____

Doctor/Individual Provider Name: _____

Specialty/Type of Provider: _____

Ph#:_____ Fax#_____

Address:_____

City, State, Zip:_____

Request #2:

Clinic/Practice or Facility Name: _____

Doctor/Individual Provider Name: _____

Specialty/Type of Provider: _____

Ph#:_____ Fax#_____

Address:_____

City, State, Zip:_____

Request #3:

Clinic/Practice or Facility Name: _____

Doctor/Individual Provider Name: _____

Specialty/Type of Provider: _____

Ph#:_____ Fax#_____

Address:_____

City, State, Zip: _____

Please email to providers@healthwestonline.com or fax to (888) 505-3028