PROVIDER REQUEST FORM

The Provider Request Form provides the necessary information for a Payer Compass Patient Advocate to contact provider(s) on your behalf to explain your health plan and to answer any questions they may have.

Please complete this form and send it via email to *providerrequest@payercompass.com*.

Employee/Member Information

First and Last Name:

Employer Group Name:

Phone Number: Email:

Please provide the following information for the provider(s) you would like us to contact:

Provider LAST Name: **Provider FIRST Name:**

Practice Name (If different than above):

Office Phone Number:

Specialty:

Street Address:

City: **State:** **Zip Code:**

Patient Name: **Patient Date of Birth:**

New Patient ☐ **or Current Patient** ☐

Do you have an appointment scheduled? **If so, Date:**

Provider LAST Name: **Provider FIRST Name:**

Practice Name (If different than above):

Office Phone Number:

Specialty:

Street Address:

City: **State:** **Zip Code:**

Patient Name: **Patient Date of Birth:**

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