SEVA CARE
10996 Four Seasons Pl, 100A
Crown Point, IN 46307

Provider Request Form

Provider Information

- Full Name and Degree: _____
- Medical Designation (Please select one option below)

  ❑ MD ❑ DO ❑ PA ❑ NP
- Gender: ❑ Male ❑ Female
- Specialty: _____

Practice Location Information

Is the provider part of a group? ❑ Yes ❑ No

- Facility / Group Name: _____
- Address: _____
- City, State, Zip Code: _____
- Phone Number: _____ Fax Number: _____

We will make every attempt to contract your provider. Until such time that your provider is in-network, please use an in-network provider.

Member Information & Signature

Do you have an appointment scheduled with this provider? ❑ Yes ❑ No **Appointment date** _____

_____
Primary Policy Holder – Printed Name **Policy Number**

_____ _____ _____
Requestor Name **Relation to Policy Holder** **Email Address**

_____
Phone Number

_____
Signature **Date**

Please return the completed form to sevacare@qualexahealthcare.com