P.O. Box 30192
Salt Lake City, UT 84130
800-538-5054
selecthealthphysician.org

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Provider Contact Information

To help us communicate with you in the timeliest manner possible, please complete and submit this form.

PRACTICE INFORMATION

Practice/Clinic Name______________________________

Address______________________________

City________________ State______ Zip______ Phone(_____)__________

Office Manager Name______________________________

Phone(_____)__________ Email____________________

BILLING OFFICE

Billing Office Name______________________________

Address______________________________

City________________ State______ Zip______ Phone(_____)__________

Billing Manager Name______________________________

Phone(_____)__________ Email____________________

ELECTRONIC MEDICAL RECORD (EMR)

Vendor____________________ Software Version________________

PROVIDER INFORMATION

In the spaces provided below, list the physicians and other healthcare professionals (providers) practicing in your clinic. Attach a separate sheet if additional space is needed.

Provider____________________ Specialty____________________

Provider____________________ Specialty____________________

Provider____________________ Specialty____________________

Provider____________________ Specialty____________________

Provider____________________ Specialty____________________

Provider____________________ Specialty____________________

Please return the completed form to Provider Relations via one of the following methods:

Email: provider.development@selecthealth.org

Fax: 801-442-0776 Attn: Provider Relations

Mail: SelectHealth Provider Relations
5381 Green Street
Murray, UT 84123

View your directory information at **selecthealthphysician.org**. Click on “Provider & Facility Search.”

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