Form #4929 (04/24)

PHYSICIAN/PROVIDER DATA LIST REQUEST

Name: ______________________________ Practice/Dept: ________________________________

Phone or Ext.: __________________ Email: ______________________________ Date: __________

Select all that apply: ☐ Physician (MD, DO, Etc.) ☐ APP (NP, PA, Etc.) ☐ Office Managers

Select Audience: ☐Cadillac Hospital ☐Charlevoix Hospital ☐Grayling Hospital ☐Kalkaska Memorial
☐Manistee Hospital ☐Munson Medical Center ☐Otsego Memorial ☐ Paul Oliver Memorial

Specialties: ____

What is the purpose of the communication?

☐ Provider Departure (Please specify: i.e. Retired, moving, termination, etc)

☐ New Provider Promotion/Referral

☐ Provider Education/Materials

☐ Marketing

☐ Other ____

Type of communication: ☐ Physical Mailing ☐ Digital/Email ☐ Both

Date you intend to send communication: ___________

Please attach the content you plan to send.

Email completed form: Provider Services at MHC-MSOWData@mhc.net
You will be notified when your request is approved/denied.
Questions: MHC-MSOWData@mhc.net