SELECT HEALTH NETWORK

PROVIDER LEAVE OF ABSENCE NOTIFICATION FORM

Select Use Only:
Notification Date:_____

Please Print

Provider Information

Practitioner Name	
Practice Name	
Practice Address	
City, State, Zip	
Phone Number	
Fax Number	
Practice Manager	
Practice Manager e-mail address	

Leave Of Absence Detail

Start Date	
Estimated Return Date	
Reason for Leave	

Completion of this form is required to ensure accurate claim processing
Return completed form to Select Health Network, Provider Relations, at (574) 283-5950

314 W. Catalpa Dr., Ste. A • Mishawaka, IN 46545
Phone: (574) 283-5959 • Fax: (574) 283-5950