



DMC Care

DETROIT MEDICAL CENTER

Provider Orientation Request Form

Please Print Clearly

OFFICE/PRACTICE MANAGER CONTACT INFORMATION

Contact Person: _____

Phone Number: _____ Fax _____

Email Address: _____

OFFICE REQUESTING ORIENTATION

Practice Name _____
Address: _____
Ste: _____
City, St, Zip _____
Office Phone _____
Office Fax: _____

Provider requesting In service : _____

Partnering Providers

First Name: _____ Last Name _____

First Name: _____ Last Name _____

First Name: _____ Last Name _____

Issues/Concerns:

*****INTERNAL USE ONLY*****

ATTN: Ruth Evans
 DMC Care Provider Services
 4707 St. Antoine G-20
 Detroit, MI 48201
 P (866) 494-1247 F (313) 313-745-7679
revans@dmc.org

Please fax or email the form. The Provider Services Dept will gladly respond within 48 hours of receipt.

Date: