



Please use this form to give us feedback on the information found in our online provider directory.

Enter today's date and your contact information.

Date (mm/dd/yyyy):			
First Name:		Last Name:	
Email address:		Phone number:	

If your feedback pertains to a specific doctor record, please complete Section 1; a specific facility, Section 2; all other, Section 3.

Section 1: Feedback about doctor records. Enter information about the doctor as it appears in the directory:

Doctor's last name:		M.I.:		First name:	
Doctor # (appears below the doctor's name):		Doctor's group number (if applicable):			

Tell us your recommended changes (do not complete sections where no change is recommended):

Doctor's last name:		M.I.:		First name:	
Doctor # (appears below the doctor's name):		Doctor's group number (if applicable):			
Group Name (if applicable):					
Practice Location Street Address:					
Practice Location City:		State:		Zip:	
Practice Phone #:			Practice Fax #:		
Other:					

Section 2: Feedback about facility records. Enter information about the facility as it appears in the directory:

Facility Name:		Facility # (appears below facility name):	
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Tell us your recommended changes (do not complete sections where no change is recommended):

Facility Name:		Facility # (appears below facility name):			
Facility Street Address:					
Facility City:		State:		Zip:	
Facility Phone #:		Facility Fax #:			
Other:					

Section 3: All other. If your feedback does not pertain to a specific doctor or facility, please describe the section of the directory to which your feedback applies and any recommended changes:

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Fax the completed form to 866.561.9260 or email it to: CCICredentialing@Connecticare.com.