AVĒSIS PROVIDER REQUEST

Please complete this form if you are a provider interested in joining the network or a member nominating a provider or provider practice to be in network. Please return to this form to ProviderRecruitment@Avesis.com. Once Avesis receives your request we will follow up within 90 days.

Plans (Commercial/Government):	Provider Type (Dental/Vision and Specialty):

PROVIDER NAME:		
OFFICE NAME:		
ADDRESS 1:	ADDRESS 2:	
CITY:	STATE:	ZIP:
OFFICE PHONE:	EMAIL:	

Additional Comments: