



# Physician Reviewer Application

Please complete the following information:

Name: \_\_\_\_\_ Title: MD or DO

Specialty: \_\_\_\_\_

Office address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

e-mail address: \_\_\_\_\_

\_\_\_\_\_

Return this completed form to:

Joy Ryan  
Medical Records Coordinator  
North Dakota Health Care Review, Inc.  
800 31st Ave. SW  
Minot, ND 58701

or fax to: 701.838.6009