



Provider Nomination

Group Name: _____

Date of Request: _____

Requester Information

Requester's Name: _____

Requester's Phone: _____

Requester's Address: _____

Requester's City, State, Zip: _____

Your information will be kept strictly confidential and will be used only by the Health Plan to contact you for more information about the providers you are nominating.

Provider Information

Name: _____

Telephone: _____

Specialty: _____

Group Name: _____

Group Address: _____

Name: _____

Telephone: _____

Specialty: _____

Group Name: _____

Group Address: _____

Name: _____

Telephone: _____

Specialty: _____

Group Name: _____

Group Address: _____

Fax this completed form to 412-454-5664.

For more information, call Member Services at 1-888-876-2756.