



PROVIDER NOMINATION TO PARTICIPATE FORM

In an effort to provide the maximum benefits for our members, we will contact physicians or other providers to encourage their participation in our PPO networks.

Name of Provider:			
Provider's Specialty:			
Contact Person:			
Contact Phone Number:	()		
Office Manager (if known):			
Practice / Facility Name:			
Location	Street Address:		
	Suite Number:		
	City, State & Zip:		
Are you a patient?	YES	NO	
Member/Patient making Nomination Request:			
Member/Patient Phone Number: (In case we need additional information)	()		
Insurance Company Name:			
Employer:			
Date of Request:	/ /		
Reason for Request:	Appointment Pending?	YES	NO
	If YES, Date of Appt?	/ /	

Please complete and return this form to Cathy Ontiveros, NAMCI/Premier Provider Relations Representative, at P.O. Box 18788, Huntsville, AL 35804. You may also fax to 256-532-2756 or email to cathy.ontiveros@namci.com.