MULTI*PLAN* NOMINATION FORM

TO BE COMPLETED BY PATIENT

To nominate your Provider into the **Multi***Plan* Network, please complete this form with your provider.

Patient Name: _____

Health Plan Sponsor/Administrator/Insurance Company: _____

TO BE COMPLETED BY **PROVIDER**

MAIL TO:

MULTIPLAN
PRACTITIONER
RECRUITMENT DEPT.
115 FIFTH AVENUE
7TH FLOOR
NEW YORK, NY 10003

TEL: 800-546-3887
FAX: 212-627-3723

Or Visit Our Website at:
www.multiplan.com

I would like information on becoming a preferred provider in the **Multi***Plan* Network.

Physician Name:
(Last)_____

(First)_____(Initial)_____

Office Address:
Street _____

City _____State_____Zip_____

Telephone # (____)_____

Fax # (____)_____

Specialty _____

TIN _____

Hospitals at which you have admitting privileges:

_____
_____
_____

Physician / Office Manager signature:_____

Are you part of a group? YES_____ NO_____

Are there other members in your practice who would be interested in joining? YES_____ NO_____

Individuals may nominate providers for participation in the network by either submitting this nomination form directly or by having their physician submit the nomination form to the address indicated. A nomination by the member does not guarantee that the provider will automatically be added to the network.