and

The Emerald Health Network

An Interplan Health Group Company

Provider Nomination Form

If you would like your current provider to receive information about becoming a Preferred Provider, complete this form and return it to the address checked below. The provider named will then receive application information for review.

Your submission of this referral form is not a guarantee that the provider named will become a Preferred Provider as not all wish to become a Preferred Provider and not all meet qualifying criteria.

Provider Name: ______________________________

Provider Specialty: ______________________________

Provider Address: ______________________________

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Provider Phone: ______________ Provider Fax: ______________

Requestor Type: ______________________________
(Payor, Patient, Provider)

Requestor Name: ______________________________

Requestor Address: ______________________________

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Requestor Phone: ______________ Requestor Fax: ______________

Employer Group: ______________________________

For Internal Staff Use Only

Date Received: ______________________________

Received By: ______________________________

Action Taken: ______________________________

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Please mail to: Emerald Health Network, Tower at Erieview, 24th Floor, 1301 E. 9th St., Cleveland, OH 44114
Attention: Provider Networks

Or Fax to: 216-479-2039