



Provider Nomination Form

If your physician / provider is not a current participating provider with Nevada Preferred Healthcare Providers (Nevada Preferred) and you wish him / her to possibly become one, please complete the information below and send it to the address noted (forms filled out by the physician / provider will not be accepted). It is our policy that every provider must be credentialed to establish eligibility, appropriate licensure(s), malpractice insurance and a willingness to participate in a managed care program. Therefore, a provider will not automatically be extended an invitation to join one of our PPO networks.

Date: _____

<p>Internal Use Only: Date Received: _____ Name of Contracting Specialist Assigned: _____</p>

Physician / Provider Information:

Physician / Provider Name: _____

Physician / Provider Address: _____

Phone Number: _____

Physician / Provider Specialty: _____

Person Requesting Provider Addition:

Contact Name: _____ Ph: _____

Insured's Name: _____ Ph: _____

Insured's Employer's Name: _____



PLEASE FAX THE COMPLETED TO:

Southern Nevada

Northern Nevada

Fax: 702.871.4737

Fax: 775.770.9043