



## PRACTITIONER NOMINATION FORM

If you have determined that your physician or other healthcare practitioner of choice is not participating in The MultiPlan Network<sup>®</sup>, please complete the information as instructed below and mail or fax it to:

**MultiPlan Practitioner Recruitment**  
115 Fifth Avenue, 7<sup>th</sup> Floor  
New York, NY 10003  
(212) 741-2201 (fax)

<b>ABOUT YOU</b>	Your Name: _____ Your Health Plan Administrator: _____
<b>ABOUT THE PRACTITIONER TO BE NOMINATED</b>  Please enter as much information as you can. Required fields are identified with an asterisk (*).	<b>Physician Name:</b> Lastname* _____ Firstname* _____ Initial* _____ <b>Practice Location:</b> Street* _____ City* _____ State* _____ Zip* _____ Telephone _____ Fax _____ <b>Other Identifying Information:</b> Specialty (e.g. pediatrics, cardiology, psychiatry, internal medicine): _____ Degree (e.g., MD, DO) _____ Tax ID # _____ Medical Group (if applicable) _____ <b>Hospital Affiliations:</b> Please list the hospital(s) at which this physician has admitting privileges, if you know them: _____ _____ _____

Thank you for your nomination. We will invite the practitioner to submit an application. If our credentialing requirements are met, he/she will be added to the network. This process may take from 30-90 days.