

## Health Care Professional Nomination Form

Would you like to nominate a provider to be included in our contracted network of providers? If you do, then simply fill out this nomination form and send it to us. We will contact the provider regarding our credentialing process. It's that easy.

### Provider Information

Provider Name: \_\_\_\_\_

Clinic Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Clinic Telephone: \_\_\_\_\_

### Why do you feel this provider should be in the Program?

Quality of service

Location

Results

Referral from friend or other

Additional Comments:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Your Information (Optional)

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Telephone: \_\_\_\_\_

After completing, please mail or fax this form to ACN Group / PacifiCare Program  
Provider Nominations  
P.O. Box 212  
Minneapolis, MN 55440-0212  
or Fax to 763-595-3333

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Oklahoma Policy Numbers: OKEOC 2005, GHC SMGRP 2005-OK, GHC500-04-OK and INDPPO-OK 10/04