

# PROVIDER NOMINATION FORM

DATE: \_\_\_\_\_

## EMPLOYEE INFORMATION

EMPLOYEE NAME: \_\_\_\_\_

EMPLOYER NAME: \_\_\_\_\_

EMPLOYEE ADDRESS:

\_\_\_\_\_

Street/Apt#

City

State

Zip Code

EMPLOYEE CONTACT INFORMATION:

\_\_\_\_\_

Email Address

\_\_\_\_\_

Phone Number

CURRENT PLAN NETWORK OPTION: PHCS

## PHYSICIAN INFORMATION

PHYSICIAN NAME: \_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_

PRIMARY SPECIALTY: \_\_\_\_\_

PHYSICIAN ADDRESS:

\_\_\_\_\_

Street/Apt#

City

State

Zip Code

ARE YOU A CURRENT PATIENT OF THE ABOVE PROVIDER? YES NO

[WWW.BENEFITHEALTHPLAN.COM](http://WWW.BENEFITHEALTHPLAN.COM)

PHONE: 844-580-2474

EMAIL: [CUSTOMERSUPPORT@BHPI.COM](mailto:CUSTOMERSUPPORT@BHPI.COM)