

## PROVIDER NOMINATION / REQUEST TO JOIN FORM

I would like the provider listed below to receive an application packet to participate in the ChoiceCare Network. I understand that ChoiceCare retains final authority for approving membership in the Network. I also understand that ChoiceCare may use my name when soliciting the provider's participation.

### **Provider Information**

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

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

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

Telephone # (please include area code): \_\_\_\_\_

Group Name/Affiliation: \_\_\_\_\_

Specialty: \_\_\_\_\_

### **Requestor Information**

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

Are you a:  Member  Healthcare provider  Humana Sales Rep.  
 Broker  Other \_\_\_\_\_

Please list the place of work through which you or a family member purchased your health insurance: \_\_\_\_\_

Requestor's Address: \_\_\_\_\_

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

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

Mail or fax completed forms to:  
ChoiceCare Network Development  
P.O. Box 19013  
Green Bay, WI 54307  
Fax: 800-626-1686