OhioHealth Group

Provider Nomination Form

Nomination Guidelines

1. To nominate a provider to one of the OhioHealth Group networks, please complete this form and fax it to Provider Network Services at 614-566-0484 or mail to OhioHealth Group, Attn: Provider Network Services, 445 Hutchinson Avenue, Suite 300, Columbus, OH 43235.

2. The Member Information section is to be completed by the person completing this form.

3. The Provider Information section should be filled in with information on the provider that you would like to nominate for participation in the network. Please include as much information as possible.

4. Once the nomination forms are received, our contracting team will evaluate the nomination and send applications to the providers. Please note that all providers must meet OhioHealth Group guidelines and criteria for network participation.

Member Information

Your Name:		Date:	
Telephone Number:		Employer Group Name:	
Current Network (Please circle one):	HealthReach HealthReach Advantage	HealthReach Preferred HealthReach Prime	

Provider Information

Provider Name:		Provider Specialty:	
Provider Address:			
Provider Group Name:		Telephone Number:	
Why would you like the provider to participate in one of the OhioHealth Group Networks:			

For Provider Network Services Use Only

Date Received:		Date Sent Application:	
Accepted or Denied:		Reason:	