Provider Nomination Form

Nomination Guidelines

1. To nominate a provider to one of the OhioHealthy networks, please complete this form and email it to the Provider Relation mailbox, providerrelations@ohiohealthyplans.com.

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

3. The Provider Information section should be completed 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 notification forms are received, our contracting team will evaluate the nomination and send applications to the provider. Please note that all providers must meet OhioHealthy guidelines and criteria for network participation.

Member Information			
Your Name:		Date:	
Telephone Number:		Employer Group Name:	
Current Network (Please circle one):	OhioHealthy Preferred OhioHealthy Network		

Provider Information			
Provider Name:		Provider Specialty:	
Provider Address:			
Provider Group Name:		Telephone Number:	
Please select the network in which you have coverage: _____ OhioHealthy PREFERRED _____ OhioHealthy NETWORK			
Why would you like this provider to participate in the OhioHealthy network(s):			

For Provider Network Services Only			
Date Received:		Date Sent Applications:	
Accepted or Denied:		Reason:	