



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  
8111 LBJ Freeway, Suite 200  
Dallas, Texas 75251  
Fax: 972 643 1799