PROVIDER NOMINATION FORM

DATE: ___________

MEMBER INFORMATION

Member Name: ______________________________ Contact Telephone: (___) ______________

Group Name: ______________________________

CHIROPRACTIC PROVIDER INFORMATION

Name: ______________________________

Office Name (if applicable): ______________________________

Office Phone: (___) ______________ Office Fax: (___) ______________

Office Address: ______________________________

Street City State Zip code

ACUPUNCTURE PROVIDER INFORMATION

Name: ______________________________

Office Name (if applicable): ______________________________

Office Phone: (___) ______________ Office Fax: (___) ______________

Office Address: ______________________________

Street City State Zip code

Upon receipt, our staff will contact the provider(s) listed above to see if they would like to join our network of participating providers. Please allow 4-6 weeks for recruitment efforts to be completed. Thank you for your nomination.

Submit Form by:

Mail: PhysMetrics P.O. Box 25220 Fresno, CA 93729-5220 Fax: 888.439.4819

Call: 877.519.8839

Email: info@physmetrics.com