healthfirst
Health Insurance for New Yorkers

Provider Nomination Form Instructions

At Healthfirst, we're always looking to expand our network of quality doctors. What better way than to listen to members like you? If you know of a healthcare provider who's not in the Healthfirst network and you'd like him or her considered, talk to the provider. If the provider is interested, complete the Provider Nomination Form and return it to us at the address shown on the form. If you're not sure whether a provider is currently in the Healthfirst network, check with the provider, see our Provider Directory, or visit **HFDocFinder.org**. **Please note that this nomination does not guarantee that your provider will be added to our network.** Providers must meet our network requirements and sign an agreement.

Please review the following instructions before completing the Provider Nomination Form.

Your Information

- Print the Member ID found on your Healthfirst Member ID card
- Print your name (First Name, Last Name) as shown on your ID card
- Print your mailing address
- Print your telephone number in case we need to reach you to verify any information you have provided
- Check the box next to your plan type

Provider Information

- Print the provider's name
- Print the provider's location (provider address)
- Print the provider's office phone number (starting with area code) and email address (if available)
- Check the box for the provider's specialty: Primary Care Provider or Specialist
- Print the provider's hospital affiliation (if known)

If you have any questions or need additional help, please call the Member/Participant Services phone number located on the back of your Member ID card. We can help you in English, Spanish, Chinese, and other languages. If you require in-person assistance with filling out this form, you may visit the nearest Healthfirst Community Office. Hours and locations are available online at **Healthfirst.org/healthfirst-community-office**.

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Provider Nomination Form

Nominated by

Your Name _____ Member ID _____
Address _____
City _____ State _____ Zip _____
Phone _____ Email* _____

Plan Type:
- ☐ AbsoluteCare FIDA Plan
- ☐ Child Health Plus (CHP)
- ☐ CompleteCare Plan (HMO SNP)
- ☐ The Essential Plan
- ☐ Leaf or Leaf Premier Plan
- ☐ Medicaid
- ☐ Medicare
- ☐ Personal Wellness Plan
- ☐ Pro or Pro Plus Plan
- ☐ Senior Health Partners
- ☐ Total Plan
- ☐ Other _____

Provider Information

Provider's Name _____
Office Address _____
City _____ State _____ Zip _____
Phone _____ Email* _____

Provider Type: ☐ Primary Care Provider (PCP) ☐ Specialist

Was this form easy to fill out? ☐ Yes ☐ No
If No, please explain why _____

For Healthfirst Use Only

Existing Healthfirst Physician? ☐ Yes ☐ No

If yes, which plan(s): ☐ CHP ☐ FIDA ☐ Medicare ☐ SHP ☐ PWP ☐ EP ☐ HFHP ☐ Medicaid ☐ QHP ☐ HFIC

Admitting privileges at which hospital? _____

Mail form to: Healthfirst Provider Relations & Contracting
Re: Physician Nomination
P.O. BOX 5168
New York, NY 10274-5168

*Please provide if available.

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