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](http://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.

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](http://Healthfirst.org/healthfirst-community-office).

---

### 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)
Provider Nomination Form

Nominated by

Your Name _____________________________ Member ID _____________________
Address ________________________________________________________________
City ___________________________ State _____________ Zip ____________
Phone __________________________ Email* ____________________________

Plan Type: □ AbsoluteCare FIDA Plan □ Medicare
□ Child Health Plus (CHP) □ Personal Wellness Plan
□ CompleteCare Plan (HMO SNP) □ Pro or Pro Plus Plan
□ The Essential Plan □ Senior Health Partners
□ Leaf or Leaf Premier Plan □ Total Plan
□ Medicaid
□ 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.
Healthfirst is the brand name used for products and services provided by one or more of the Healthfirst group of affiliated companies.

© 2018 HF Management Services, LLC 0160-18