

## Message to patient — It's easy to nominate your doctor.

1. Determine if your physician or other medical professional already participates in the First Health Network by going to the website at [www.myfirsthealth.com](http://www.myfirsthealth.com). Click on First Health Network to search for a doctor, hospital or facility following the provider search directions.
2. If your provider is not in the network, please write your name on the form below and give this entire sheet to your provider.
3. Ask your provider to complete the form and submit it directly to First Health.
4. We will follow up with your provider to discuss joining our network and gather any additional information we need.

## Message to provider — Your patient is nominating you for participation in the First Health Network.

1. To receive a participation packet and application, please fill out the form below — **all fields must be completed.**
2. Mail or fax your complete form to First Health.
3. If you have any questions, please call our Provider Relations Department at 800-937-6824.

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## Provider Nomination Form *To be completed and sent by the provider*



**Name of Patient:** \_\_\_\_\_

**Name of Client:** \_\_\_\_\_ **Employer:** \_\_\_\_\_

Yes, I would like information about joining the First Health Network.

**Provider's Name:** \_\_\_\_\_ **M.I.:** \_\_\_\_\_

**Office Contact Name:** \_\_\_\_\_

**Office Address:** \_\_\_\_\_ **Suite No.:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **Provider's Tax ID:** \_\_\_\_\_

**Degree (MD, DO, etc.):** \_\_\_\_\_ **Provider's Specialty:** \_\_\_\_\_

**Provider's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

### **All Fields must be completed.**

Mail to: First Health, Attention: Nominations Department  
750 Riverpoint Drive, West Sacramento, CA 95605, or fax to 916-374-3648.