



**ADVANTAGE CARE SELECT PROGRAM
PROVIDER NOMINATION FORM**

ADVANTAGE Care Select is interested in the doctors you would like to see added to the ADVANTAGE Care Select network. Please complete the following information and we will outreach to the doctor to gain interest in participating with the ADVANTAGE Care Select Program. Please fax this form to (317) 573-6218. In the future, check our website to see if your provider has been added. We will do our best to get your doctor added but participation is not guaranteed!

Date Request Submitted: _____

Doctor's Name: _____

Doctor's Address: _____

Doctor's Phone _____

Are you a current or past patient of this physician? (yes or no) _____

Please provide your name (or patient name) if you would like us to inform the physician of your nomination.

(Print Name) _____