



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