Provider Nomination Form

Please return completed form to:

- Email: providercontact@zelis.com or
- Fax: 504-566-9509

* Required fields

Nominator Information		
Title* (e.g. Mr., Ms, Dr.)	First Name*	Last Name*
Email*	Phone	
Employer / Insurance Carrier / Third Party Administrator		

Provider Information		
Provider Type* ☐ Group Health ☐ Dental ☐ Workers' Compensation		
Provider Name*	Provider Tax ID#	
Group / Entity / Organization*	Hospital Affiliation	
Specialty	Office Manager Name	
Provider Contact Information		
Street Address*	Suite	
City*	State*	Zip Code*
Phone*	email	

Office Use Only
PPO Network Requested:
Solicitation Start Date:

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