PROVIDER NOMINATION FORM FOR MEDSTAR SELECT AND MEDSTAR MEDICARE CHOICE PLANS

Date of Request: _____

Requester Information

Requester's Name: _____

Requester's Phone: _____

Requester's Address: _____

Requester's City, State, Zip: _____

Your information will be kept strictly confidential.

Choose Your Plan

O **MedStar Select Provider Network,** for MedStar Health's benefit-eligible associates**.**

O **MedStar Medicare Choice Provider Network**, for local community members who are eligible for federal health insurance through Medicare.

Provider Information

Name: _____

Telephone: _____

Specialty: _____

Group Name: _____

Group Address: _____

Name: _____

Telephone: _____

Specialty: _____

Group Name: _____

Group Address: _____

PROVIDER NOMINATION FORM FOR MEDSTAR SELECT AND MEDSTAR MEDICARE CHOICE PLANS

Name: _____

Telephone: _____

Specialty: _____

Group Name: _____

Group Address: _____

How to Submit this Form

Email the completed form to: MedStarProviderNetwork@MedStar.net
For more information, contact member services at 855.242.4872.