



## NETWORK PROVIDER NOMINATION FORM

**Name of Provider:**

**Provider's Specialty:**

**Contact Person:**

**Contact Phone Number:**

**Office Manager:**

**Practice / Facility Name:**

**Location Street Address:**

**Suite Number:**

**City, State & Zip:**

**Date of Request:**

**Details or Special Requests:**

Please complete and return this form NAMCI/Premier Provider Relations Representative, at P.O. Box 18788, Huntsville, AL 35804. You may also fax to 256-532-2756 or email to [cathy.ontiveros@namci.com](mailto:cathy.ontiveros@namci.com).