



## Provider Nomination Form

Date: \_\_\_\_\_

Physician Name: \_\_\_\_\_

Clinic Name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

\_\_\_\_\_

Specialty: \_\_\_\_\_ Phone: \_\_\_\_\_

Dear Dr. \_\_\_\_\_:

My health benefit plan provides a higher level of benefits when I utilize an in-network provider. NovaSys Health Network is the PPO network for my health plan.

To date there are over 11,000 providers in and around Arkansas who have joined the NovaSys Health Network. I am interested in continuing my relationship with you, and am therefore asking you to join NovaSys Health Network. I have asked NovaSys to forward an application and contract to you for consideration. If you have any questions please contact the NovaSys Provider Relations Department at 501-219-4444 or 800-294-3557.

Sincerely,

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Employer

\_\_\_\_\_  
Phone Number

Please mail, fax or mail this nomination form to:

NovaSys Health Network  
Attention: Provider Relations  
PO Box 25230  
Little Rock, AR 72211  
**Fax:** 501-219-4455