First Health

First Health Network
Provider Nomination Form

Your Relationship With Your Doctor is Important

We understand the importance of having confidence in your provider. You've built a trusting relationship and you want to keep it. Yet you can save a lot by using a provider who participates in the First Health Network. That's why we make it easy for you to nominate him or her to join. To find out if your provider already participates in the network, call the toll-free number listed on your ID card or search our electronic directory at www.myfirsthealth.com.

It's Easy to Nominate Your Provider

This is all you need to do: Simply fill out the patient section on the back and send this entire sheet to your provider. You may want to attach an addressed envelope. Here's what your provider will need to do: He or she should complete the provider portion and log on to www.aetna.com to submit an application.

Once we receive the completed application, we'll call your provider to discuss our criteria for joining our network, and gather any additional information we need.

Message to Providers

You have obviously worked hard to foster relationships with your patients. As a result, you are being asked by your patient to join the First Health Network. To join, a provider must:

- have privileges at a hospital participating in the First Health Network
- be board certified, if a specialist
- complete an application
- satisfy First Health credentialing review requirements
- sign a participating physician agreement

Simply visit us online at www.aetna.com, click on "Providers", "Working with us" then on "Join the network", or if you're a hospital or other facility, click "Join our facility network", follow the instructions under "Request participation" to complete the online application request form.

If you have any questions, please call Provider Services at 800-937-6824, or visit www.aetna.com. Your patient will be glad you did.

Due to the number of steps involved, the provider nomination process may take up to six months to complete. If you have questions, please call us at the toll-free number listed on your ID card.

To Be Completed by the Patient

Patient's First Name:

Last Name:

Employer:

Street Address:

City:

State: Zip:

Phone #:

To Be Completed by the Provider

Provider's First Name:

Last Name:

Office Address:

Ste #: City:

State: Zip:

Phone #:

Degree (MD, DO, etc.):

Speciality(s):

Contact Name:

Contact Phone #:

Provider Tax ID:

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