Montgomery County Public Schools

UnitedHealthcare Provider Nomination Form

If your physician is ***not*** currently part of UnitedHealthcare's network of doctors, and you would like your physician to be considered for the network, please follow the four steps indicated below:

1. Complete and fax the form to the number provided below.
2. After initial prescreening, the physician ***may*** be sent an application for network participation.
3. The application process is not immediately following receipt of your physician's information. Acceptance into the UnitedHealthcare network is contingent upon successful completion of our credentialing process and provider acceptance of our contracts.*
4. If you have any questions regarding the status of the application, please contact your physician directly.

* Employees may nominate providers for participation in the network by submitting this nomination form to UnitedHealthcare. Nomination ***does not*** guarantee the provider will be added to the UnitedHealthcare network.

Referring Member Information

EMPLOYEE'S NAME

E-MAIL

PHONE NUMBER

EMPLOYER'S NAME MCPS

Provider Information

LAST NAME

FIRST NAME

IS HE/SHE A PRIMARY CARE PHYSICIAN? YES NO

PRIMARY SPECIALTY

SECONDARY SPECIALTY

PRACTICE OR GROUP NAME

STREET ADDRESS:

CITY STATE ZIP CODE

COUNTY

PHONE: FAX:

Fax this completed form to—

UNITEDHEALTHCARE

ATTN: PROVIDER NOMINATIONS FOR THE MCPS HEALTH PLAN

FAX: 410-869-7564