



PROVIDER NOMINATION FORM

This form is used to request the enrollment of a health care provider in one of the following networks:

- Health Management Network (HMN)
- Arizona Medical Network (AMN)
- Rural Arizona Network (RAN)

To nominate a physician:

1. Talk to the health care provider about joining the provider network.
2. Complete and submit the Provider Nomination Form.
3. The nominated provider will receive a phone call and a contract from the Network.
4. Once the Network receives the completed contract and the provider meets the required criteria, the provider will be added to the network and directory.

HMA CANNOT GUARANTEE THAT YOUR HEALTH CARE PROVIDER WILL BECOME A PARTICIPATING PROVIDER WITHIN THIS NETWORK.

Your Name: _____

Phone: _____

Employer: _____

Provider Name: _____

Specialty: _____

Primary Address: _____

City: _____ County: _____

State: _____ Zip Code: _____

Phone: _____ Fax: _____

Office Contact: E-mail: _____