



Provider Nomination Form

Message to patient – It’s easy to nominate your doctor:

1. Determine if your physician or other medical professional already participates in the *CCN*® Network by going to the CCN website at www.ccnusa.com, clicking on “Search for a doctor, hospital or facility” and following the provider search directions.
2. If your provider is not in the network, please write your name on the form below and give this entire sheet to your provider.
3. Ask your provider to complete the form and submit it directly to CCN.
4. We will follow up with your provider to discuss joining our network and gather any additional information we need.

Message to provider – Your patient is nominating you for participation in the *CCN*® Network.

1. To receive a participation packet and application, please fill out the form below - **all fields must be completed.**
2. Mail or fax your completed form to CCN.
3. If you have any questions, please call our Provider Relations Department at 800.226.5116, or visit www.ccnusa.com and click on the Doctors & Hospitals link.

Provider Nomination Form *To be completed and sent by the provider*



Name of Patient: _____

Name of Client: _____ Employer: _____

Yes, I would like information about joining the *CCN*® Network.

Provider’s Name: _____ M.I.: _____

Office Contact Name: _____

Office Address: _____ Suite No.: _____

City : _____ State: _____ Zip: _____

Phone: _____ Provider’s Tax ID: _____

Degree (MD, DO, etc.): _____ Provider’s Specialty: _____

Provider’s Signature: _____ Date: _____

All fields must be completed.

Mail to: CCN, Attention: Nominations Department
750 Riverpoint Drive, West Sacramento, CA 95605, or fax to 916.374.3648.