

Request to Add a Doctor to Your Network

Complete this form to request to have a doctor added to your network. Completing this request does not guarantee the doctor will become contracted. If the doctor qualifies and agrees to contract with PEHP, the effective participation date will be the date the contract is finalized, not the request date. Expect the process to take about 30 to 60 days.

Doctor Information ** denotes a required field*

*Doctor's First Name: _____

*Doctor's Last Name: _____

Group/Practice Name: _____

Doctor's Email: _____

*Doctor's Phone #: _____

Doctor's Specialty: _____

Doctor's Address: _____

City: _____ ST: _____ Zip: _____

Which network do you want the doctor to join?

*Mark all that apply: **Advantage** ___ **Summit** ___ **Preferred** ___ **Dental** ___

*Your Name: _____

May we use your name when contacting the doctor? **Yes** ___ **No** ___

Please email or fax back the completed form to:

Email: providerrelations@pehp.org | **Fax:** 801-320-4006

