PROVIDER NOMINATION FORM
for
Physicians and Allied Health Professionals

This form is used to request the enrollment of a health care provider with:

Check ONE box:

☐	☐
Hawaii Community Health Alliance	**Provider Network of America**
In State (Hawaii) Network	**Out of State Network**

To nominate a health care provider:

1. **Talk to your provider about joining the network**
2. **Based on network you select (HCHA or PNOA), they will contact your provider to start the contracting process**
3. **You or your provider (physician) may contact the provider's status in the contracting process. This process may take 60-90 days to complete.**

Date: _____ **Member Name: _____**

Member contact:

Phone _____ **Email _____**

PROVIDER INFORMATION:

Name: _____ **Phone: _____**

Address: _____

City: _____ **State: _____** **ZIP: _____**

Define specialty of health care provider i.e. Primary Care Physician, Orthopedic, Endoscopy, etc.

_____

SUBMIT FORM TO PROVIDER WHICH APPLIES, OR YOUR PLAN ADMINISTRATOR, BRMS:

HCHA	**Address: P.O. Box 29988, Hon. Hi. 96820**	**or email: HCHANetwork@pswadmin.com**
PNOA	**Address: 1600 W. Broadway Rd. Ste. 300 Tempe, AZ 85282**	**or email: nominations@pnoa-ppo.com**
BRMS	**Address: 560 N. Nimitz Hwy. #209 Honolulu, HI 96813**	**or email: hiaflinfo@brmsonline.com**

THERE IS NO GUARANTEE THAT THIS HEALTH CARE PROVIDER WILL BECOME A PARTICIPATING PROVIDER WITH THE NETWORKS