SimpleTherapy® | SimpleMSK

PROVIDER NOMINATION FORM

DATE: _____

MEMBER INFORMATION

Member Name: _____ Contact Telephone: (___) _____

Group Name: _____

PROVIDER INFORMATION

Name: _____

Office Name (if applicable): _____

Specialty: _____

Office Phone: (___) _____ Office Fax: (___) _____

Office Address: _____
Street City State Zip code

Email: _____

Upon receipt of this form, our staff will contact the provider listed above to see if they would like to join our network of participating providers. Please allow us 4-6 weeks for recruitment efforts to be completed. Thank you for your nomination.

Submit Form to:

SimpleMSK
Mail: P.O. Box 25220 Fresno, CA 93729-5220

Fax: 888.439.4819
Call: 877.519.8839
Email: provider.relations@simpletherapy.com