



PROVIDER NOMINATION FORM

I, _____, (employee name) request that Allegiance Benefit Plan Management, Inc. offer this healthcare provider a participating provider contract. This will assure that my Plan will have access to cost effective healthcare service pricing.

Allegiance Benefit Plan Management
Provider Services
PO Box 3018
Missoula, MT 59806
Phone: (406) 721-2222 Fax: (406) 523-3139

Date

Employer or Group Plan Name

Physician or Practice Name

Specialty

Address

City

State

ZIP

Phone #

Fax #

Office E-mail Address

Thank you for your time and effort.