Physician/Facility Network Enrollment Form

This form is used to request the enrollment of a health care provider/facility in Provider Network of America, LLC (PNOA). Please complete the form and submit it by mail to the address below, fax or via email to registration@pnoa.com **To request that your physician/facility enrolls in the PNOA network:**

1. Talk to your health care provider about joining PNOA.
2. PNOA will send contract to the provider for review.
3. Once PNOA receives the completed contract and supporting documentation, members may then begin to receive services at the In-Network level of benefits.
4. You or your provider may contact the Provider Relations Department to determine your provider's status in the contracting process at (800) 472-2636.

PNOA CAN NOT GUARANTEE THAT YOUR HEALTH CARE PROVIDER WILL BECOME A PARTICIPATING PROVIDER WITHIN THE PPO NETWORK.

Date: _____

Member First Name: _____ Member Last: _____

Employer Name: _____ Member Birth Date: _____

Member Phone #: _____ Member Email: _____

THE FOLLOWING INFORMATION IS REQUIRED FOR PROCESSING

Provider First Name: _____ Provider Last: _____

Provider Address: _____

City: _____ State: _____ ZIP: _____

Provider Phone#: _____ FAX #: _____

Office Contact: _____ Hospital Affiliation: _____

Provider Network of America, LLC
1600 W. Broadway Road, Suite 300
Tempe, AZ 85282
Phone: (800) 472-2636 Fax: (480) 800-5872
Email: registration@pnoa.com