

OccHealth Connect Provider Nomination Form

To be used by member in the event it wishes to utilize a provider not on the master list.

Name of Member _____

Contact: _____ Phone _____

Name of Nominated Provider: _____

Name of Practice: _____

Address: _____

Phone: _____

Name of Physician Contact:

Has the physician tentatively agreed with the Letter of Understanding? Yes ___ No ___

Does the facility provide preplacement physicals? Yes ___ No ___

Does the practice accept walk-in patients between 8:30 AM and 4:30 PM?

Yes _____ No _____ If no, this nomination will not be accepted except for unusual circumstances. Please explain below:

The MIIA Rewards staff will contact you shortly. Thank you.

Fax completed form to MIIA at (617)426-9546