American Foreign Service Protective Association

Foreign Service Benefit Plan

Coventry Health Care

Provider Nomination Form

Generally, if you are retired and have Medicare A and/or B primary, it is not necessary to select a provider who is part of the Coventry Health Care National Network [the Foreign Service Benefit Plan's Preferred Provider (PPO) Network]. However, if Medicare non-covers a service, it is beneficial to use a participating provider.

Your Relationship with Your Provider Is Important.

We understand the importance of having confidence in your provider. You have built a trusting relationship and you want to keep it. Yet you can save a lot by using a provider who participates in the Plan's PPO Network. That is why we make it easy for you to nominate your provider to join the Network.

To find out if your provider already participates in the Network, search our electronic directory at:

- http://fsbp.coventryhealthcare.com/member-support/locate-a-provider/index.htm; or
- Call 202-833-4910.

It is Easy to Nominate Your Provider.

All you need to do is complete the form on the second page of this notice and click *SUBMIT*. We will contact your provider to discuss participation in the Network. If your provider is interested, we will send your provider an application. Once we receive the completed application, we will call your provider to discuss our criteria for joining our Network and gather any additional information we need.

Please note that while we will make every effort to bring your provider into the Network, completion of this form is not a guarantee that the health care provider will become part of our provider network. Also, due to the number of steps involved, the provider nomination process may take up to six months to complete. If you have any questions, please call the Plan's customer service at 202-883-4910.

American Foreign Service Protective Association

Foreign Service Benefit Plan

Coventry Health Care

Provider Nomination Form

This PDF form contains interactive fields and should be viewed with Adobe® Acrobat® or Acrobat Reader® software.

Completion of this form is not a guarantee that the health care provider will become part of the Plan's Network.

Health Care Provider's First and Last Name and Degree:

_____

Address (including suite number):_____

City: _____ State: ____ ZIP: _____

Phone: _____

I understand that this is for consideration purposes only and that the health care provider must fulfill the needs and requirements of the Coventry Health Care criteria set for providers in the network.

Your First and Last Name: _____

Address:_____

City: _____ State: ____ ZIP: _____

Date: _____

Group Number/Plan Name: _____

Click Submit to begin the nomination process.

Please note that the nomination process may be a lengthy process. We will notify you once the process is complete. Thank you for your nomination!

SUBMIT FORM