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.

Submit

If you use Outlook or Netscape Messenger for e-mail you can click the "Submit" button to the left. Otherwise please print this and mail to: Allegiance Benefit Plan Management, Inc. - C/O Provider Nomination Form - P.O. Box 3018 - Missoula, MT 59801-7703