



## PHYSICIAN SOLICITATION REQUEST FORM

Date: \_\_\_\_\_

Requested by:

Name: \_\_\_\_\_ SS#: \_\_\_\_\_

Email Address: \_\_\_\_\_ Employer: \_\_\_\_\_

Please complete the information below for the provider that you would like us to solicit for supporting our Healthgram benefit plan option. All physicians in a practice are automatically included if the practice agrees to support Healthgram.

Physician Name: \_\_\_\_\_

Practice Name: \_\_\_\_\_

Specialty (type of doctor) \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Phone Number: \_\_\_\_\_

Office/Billing Manager's Name: \_\_\_\_\_

Provider EMAIL \_\_\_\_\_

Provider website \_\_\_\_\_

Fax or mail completed form to:

Healthgram Provider Relations  
Administered by Primary PhysicianCare  
P. O. Box 11088  
Charlotte, NC 28220-1088  
Fax (704) 496-2366