

## **ILWU-PMA Provider Nomination**

### ***Great West Healthcare Preferred Provider (PPO) network***

Please send me more information about participating in the *Great West Healthcare* network.\*  
My practice information is listed below:

Plan:  PPO Access

Provider Name: \_\_\_\_\_

Specialty: \_\_\_\_\_

Hospital Affiliation(s): \_\_\_\_\_

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

City: \_\_\_\_\_

County: \_\_\_\_\_

State: \_\_\_\_\_

Zip Code: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

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

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

Optional - Member Name,  
email address &/or phone#: \_\_\_\_\_

\*I understand that this form is **only a request for information**. I will need to complete a formal application to determine if I meet the network's participation requirement.

Please send this completed form to:

***Great West Healthcare***  
**Attn: Provider Relations – Suite 1900**  
**655 North Central Ave.**  
**Glendale, CA 91203**  
**FAX 818-539-2809**