



Provider Nomination Form

Instructions: Please complete form and e-mail to NetOps@CHN.com or
Fax to (609) 631-0476 or Mail to 300 American Metro Blvd, Ste 170, Hamilton NJ 08619
Attention Network Operations

*Practitioner/Facility/Group Name

(First name, last name, and title)

*Primary Specialty

*Office Location

Telephone Number

Fax Number

Your Name

Member Name (if different)

*Employer/Insurance Company

Additional Comments

Date Submitted to CHN PPO

*Denotes required information