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Provider Nomination Form

Generally, if you're retired and have Medicare Parts A and/or B as your primary coverage, it's not necessary to select an In-Network provider.
However, you will not receive In-Network benefits for any services that Medicare does not cover when you choose an Out-of-Network provider.

Your Relationship with Your Provider is Important

We understand the importance of having confidence in your health care provider. You've built a trusting relationship and you want to keep it. Yet you can save a lot by using an In-Network provider. That's 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:

- https://www.aetna.com/dsepublic/#/rcbp; or
- Call **800-638-8432**

It's 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 **800-638-8432**.

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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.

About your health care provider:			
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 set for providers in their contractual agreement.

About you:		
Your First and Last Name		
Address		
City	State	ZIP
Rural Carrier Benefit Plan ID number (if applicable)		

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