MHBP SM
Brought to you by Aetna

Network Provider Nomination

Generally, if you're retired and have Medicare Parts A and/or B as your primary coverage, it's not necessary to select a Network provider.

However, you will not receive Network-level benefits for any services that Medicare does not cover when you choose a Non-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 a 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 on the Locate a Provider page at www.MHBP.com

  Or,

- Call us at 1-800-410-7778

It's Easy to Nominate Your Provider

All you need to do is complete the form on the next page and click SUBMIT. We'll contact your provider to discuss participation in the Network and send an application if he/she would like to join. Once we receive the completed application, we will call your provider to discuss our criteria for joining the Network and gather any additional information we need.

Please note that while we make every effort to bring your health care provider into the Network, completion of this form is not a guarantee that he/she will become part of our provider network. Also, due to the number of steps involved, the process may take several months to complete.

If you have any questions, please call us at 1-800-410-7778.

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Network Provider Nomination

This form contains interactive fields and should be viewed with Adobe® Acrobat® or Acrobat Reader® software.

Completion of this form does not guarantee that the nominated health care provider will become part of the Plan's network.

About your health care provider:			
First Name	Last Name		Degree or credential (MD, DO, RN, PA, etc.)
Address			Suite or room number
City	State	ZIP Code	Phone

I understand that this form is for consideration purposes only and that the health care provider must agree to fulfill the requirements established in a contractual agreement.

About you:			
First Name	Last Name		
Address			Apt, Unit or Lot number
City	State	ZIP Code	Phone

Date: _____

Group Number/Plan Name: **Mail Handlers Benefit Plan (MHBP)**

Click **SUBMIT** to begin the nomination process. SUBMIT

Please note that this may be a lengthy process. We will notify you once the process is complete. Thank you for your nomination!