

# LARGE GROUP HOSPITAL, MEDICAL GROUP, PROVIDERS, AND Rx SEARCH REQUEST

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**Client Name:** \_\_\_\_\_

**Broker Name:** \_\_\_\_\_

PROVIDER NAME* (REQUIRED)	STREET ADDRESS, CITY, ZIP CODE (REQUIRED)	FED TAX ID (OPTIONAL)	RX NAME AND DOSAGE	SELECT PLANS FOR REVIEW	
				Aetna HMO	<input type="checkbox"/>
				Aetna Value Network (AVN)	<input type="checkbox"/>
				Aetna HMO Deductible Network	<input type="checkbox"/>
				Aetna Basic HMO	<input type="checkbox"/>
				Aetna Whole Health Southern CA HMO	<input type="checkbox"/>
				Aetna Open Access Managed Choice (OAMC)	<input type="checkbox"/>
				Anthem HMO	<input type="checkbox"/>
				Anthem Select HMO	<input type="checkbox"/>
				Anthem Priority Select HMO	<input type="checkbox"/>
				Anthem Vivity HMO	<input type="checkbox"/>
				Anthem Prudent Buyer PPO	<input type="checkbox"/>
				Anthem Select PPO	<input type="checkbox"/>
				Blue Shield Access+ HMO	<input type="checkbox"/>
				Blue Shield Local Access+ HMO	<input type="checkbox"/>
				Blue Shield Trio ACO HMO	<input type="checkbox"/>
				Blue Shield SaveNet HMO	<input type="checkbox"/>
				Blue Shield Full PPO	<input type="checkbox"/>
				Cigna HMO	<input type="checkbox"/>
				Cigna Select HMO	<input type="checkbox"/>
				Cigna Value HMO	<input type="checkbox"/>
				Cigna PPO	<input type="checkbox"/>
				Cigna Open Access Plus (OAP)	<input type="checkbox"/>
				Cigna Local Plus	<input type="checkbox"/>
				Health Net Full HMO	<input type="checkbox"/>
				Health Net CanopyCare	<input type="checkbox"/>

\*Provider is the Doctor, Dentist, Vision, Hospital, Urgent Care, or Medical Group.

Please submit completed form to: [accountmanagement@wordandbrown.com](mailto:accountmanagement@wordandbrown.com)

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