

SMALL 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 Choice POS II <input type="checkbox"/>
				Aetna Open Access Select <input type="checkbox"/>
				Anthem Pathway HMO <input type="checkbox"/>
				Anthem Guided Acces <input type="checkbox"/>
				Anthem PPO <input type="checkbox"/>
				Anthem Choice PPO <input type="checkbox"/>
				Anthem EPO <input type="checkbox"/>
				Prominence Health First <input type="checkbox"/>
				Prominence Preferred Health Care Network <input type="checkbox"/>
				Prominence Universal Health Network <input type="checkbox"/>
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*Provider is the Doctor, Dentist, Vision, Hospital, Urgent Care, or Medical Group.

Please submit completed form to: accountmanagement@wordandbrown.com

PROVIDER NAME* (REQUIRED)	STREET ADDRESS, CITY, ZIP CODE (REQUIRED)	FED TAX ID (OPTIONAL)	RX NAME AND DOSAGE	SELECT PLANS FOR REVIEW
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