

ILWU-PMA Provider Nomination

Great West Healthcare Preferred Provider (PPO) network

Please send me more information about participating in the *Great West Healthcare* network.* My practice information is listed below:

Plan: PPO Access

Provider Name: _____

Specialty: _____

Hospital Affiliation(s): _____

Mailing Address: _____

City: _____

County: _____

State: _____

Zip Code: _____

Telephone Number: _____

Email Address: _____

Office Manager's Name: _____

*I understand that this form is **only a request for information**. I will need to complete a formal application to determine if I meet the network's participation requirement.

Please send this completed form to:

Great West Healthcare
Attn: Provider Relations – Suite 1900
655 North Central Ave.
Glendale, CA 91203
Fax: 818-539-2809