

Unison Health Plan Provider Nomination Form

Please use this form to identify providers to whom you refer your members on a regular basis. Unison will make every effort to ensure that these providers are a part of our network.

Provider Name: _____
Specialty: _____ Phone: _____
Address: _____
City, State, Zip: _____

Provider Name: _____
Specialty: _____ Phone: _____
Address: _____
City, State, Zip: _____

Provider Name: _____
Specialty: _____ Phone: _____
Address: _____
City, State, Zip: _____

Community Resources

Our job is not only to coordinate care with healthcare providers, but also to assist our Members in improving their quality of life through careful coordination and collaboration with community groups. Please list any community resources with whom Unison may want to partner.

Agency Name/Event: _____
Address: _____
City, State, Zip: _____
Phone/Web Address: _____

Agency Name/Event: _____
Address: _____
City, State, Zip: _____
Phone/Web Address: _____

Please return completed forms via fax to 614.794.0562