First Choice Health

PPO Network
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ACT Group Form

First Choice Health has updated the Act Group Form. Effective immediately, please use the updated Group Form below. Submit this completed form to your Account Manager or email it to PPOAccountManagement@fchn.com.

ADD GROUP

Contract Holder Information (Per agreement, Contract Holder shall provide group notification 30 days prior to implementation)

Contract Holder Name:		Date Submitted:
Contact Name:	Contact Phone #:	Contact Email:

Employer Group Information (REQUIRED: a copy of group medical ID card with FCH logo)

Group Name:	Group ID #:	City:	State:	Zip Code:	# of Employees:	Effective Date:

Broker Information (Complete this section if applicable)

Broker Company:	Contact Name:	Contact Phone #:	Contact Email:

Network Access (Only check boxes that apply; only select National Wrap if access is through FCH)

☐ First Choice Health (Alaska, Idaho, Montana, North Dakota, Oregon, South Dakota, Washington, Wyoming)

National Wrap (Select one): ☐ First Health ☐ MultiPlan *(REQUIRED: Copy of group medical ID card with National Wrap and FCH logo)*

Claim Submission / Benefits & Eligibility (For **bold** fields, refer to the group medical ID card)

☐ First Choice Health (FCH)	PO Box 2289, Seattle, WA 98111-2289
Payor Name:	**Payor Address:**
Benefits & Eligibility provided by:	**Benefits & Eligibility Phone #:**

CHANGE GROUP

Contract Holder Information

Contract Holder Name:		Date Submitted:
Contact Name:	Contact Phone #:	Contact Email:

Employer Group Information (REQUIRED: a copy of group medical ID card with FCH logo)

Group Name:	Group ID #:	CH Group ID # (If Applicable):	# of Employees:	Effective Date:

Network Access (Only check boxes that apply; only select National Wrap if access is through FCH)

☐ First Choice Health (Alaska, Idaho, Montana, North Dakota, Oregon, South Dakota, Washington, Wyoming)

National Wrap (Select one): ☐ First Health ☐ MultiPlan *(REQUIRED: Copy of group medical ID card with National Wrap and FCH logo)*

TERM GROUP

Contract Holder Information (Per agreement, Contract Holder shall provide group notification 30 days prior to termination)

Contract Holder / Payor Name:		Date Submitted:
Contact Name:	Contact Phone #:	Contact Email:

Employer Group Information

Group Name:	Group ID #:	# of Employees:	Termination Date:
Reason for Termination (REQUIRED):			

Run-in & Run-out Information

Current Admin providing Run-out (if applicable):	From Date:	Thru Date:
New Admin providing Run-in (if applicable):		From Date: