



Network Option Form For North Carolina Providers

Instructions: Please select IN or Out for each network - **One form per provider**

	OPT IN	OPT OUT
Ambetter (only)	<input type="checkbox"/>	<input type="checkbox"/>
Clear Spring Health Plan – Medicare Advantage	<input type="checkbox"/>	<input type="checkbox"/>
First Health Network	<input type="checkbox"/>	<input type="checkbox"/>
MultiPlan Auto	<input type="checkbox"/>	<input type="checkbox"/>
MultiPlan / PHCS	<input type="checkbox"/>	<input type="checkbox"/>
Prime Health Services	<input type="checkbox"/>	<input type="checkbox"/>

Print Provider's Name: _____

Provider's Signature: _____

Date: _____ Phone number: _____

Tax Id (s) effected: _____ (as on claims)

Provider's Individual NPI _____

Please fax completed form to 678-990-1124 or email to Credentiaing@ActivHealthCare.com