1926 Northlake Pkwy, Suite 100 • Tucker, GA 30084-7069
ph 770.455.0040 • toll free 888.635.0459 • fax 770.455.6188

## MultiPlan AUTO LIABILITY OPTION FORM

As a Participating Provider of ActivHealthCare, Inc. (AHC) I, ________________________________ (Print Provider's Name) choose to (initial by your selection below to Opt-In or Opt-Out):

_______ I elect to **Opt-In** or Participate in all products of the MultiPlan, PHCS and Beech Street networks. I understand that these networks products include Group Medical, Auto Medical and Workers' Compensation product lines as stated on the Term Summary Sheet provided by AHC.

_______ I elect to **Opt-In** or Participate in only the Group Medical and Workers' Compensation products, but not the Auto Medical product, of the MultiPlan, PHCS and Beech Street networks.

_______ I elect to **Opt-Out** or Not Participate in the MultiPlan, PHCS and Beech Street networks. I understand that by choosing to Not Participate, AHC will terminate my participation in the Group Medical and Workers' Compensation networks of MultiPlan, PHCS and Beech Street. The termination process from the existing Group Medical and Workers' Compensation products may take up to 90 days from the first of the month following notification to AHC. Also, I understand that I have the responsibility to notify my affected patients of this decision.

Provider Signature: ______________________________________ Date: ____________________

Provider Tax ID #: _______________________________

Provider Phone # _______________________________

NOTE: We need to receive one response per credentialed provider. If multiple providers are in the same practice, we need a separate form for each individual provider.

If you have any questions, Please contact Mark Brickhouse: Phone 770-455-0040 x 108 or email MBrickhouse@ActivHealthCare.com.

**Fax completed form to 678-990-1124**

(No cover sheet is needed)

OR

Mail to above letterhead address