First Choice Health™
Healthy Employees. Healthy Companies.™

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 included with this communication. For any questions regarding this form contact your Account Manager or email PPOAccountManagement@fchn.com.

New **Broker Information** Section:

- Add Broker name and contact information.

NOTE: Apple's Mac Computers and the **Preview Application** will **NOT** work with this FILLABLE PDF FORM. You must use the FREE Adobe Acrobat Reader Application that can be downloaded here.

ACT Group Form

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 E-mail:

Employer Group Information (REQUIRED: a copy of group ID card with FCH's PPO Network logo)

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

Broker Information (Complete this information if applicable)

Broker Company:	Contact Name:	Contact Phone #:	Contact E-mail:

Network Access (Check each box that applies; Custom access available only with approval from Account Management)

- ☐ Full Network (All states)
- ☐ Oregon Access (Oregon)
- ☐ Washington Access (Alaska, Idaho, Washington)
- ☐ Montana Access (Colorado, Montana, Nebraska, North Dakota, South Dakota, Wyoming, Utah)
- ☐ Custom Access (REQUIRED: Approval from Account Management)

Add the Number of Employees (Complete the box for each state if applicable.)

Alaska ☐	Idaho ☐	Montana ☐	North Dakota ☐	Oregon ☐	South Dakota ☐
Washington ☐	Wyoming ☐	Colorado ☐	Nebraska ☐	Utah ☐	

National Wrap (Select one if access is thru FCHN): ☐ First Health ☐ MultiPlan *(REQUIRED: Medical card with National wrap and FCHN logo)*

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

☐ First Choice Health Network (FCHN)	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 E-mail:

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

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

CHANGE GROUP

Network Access (Check each box that applies; Custom access available only with approval from Account Management)

- [ ] Full Network (All states)
- [ ] Oregon Access (Oregon)
- [ ] Washington Access (Alaska, Idaho, Washington)
- [ ] Montana Access (Colorado, Montana, Nebraska, North Dakota, South Dakota, Wyoming, Utah)
- [ ] Custom Access (REQUIRED: Approval from Account Management)

National Wrap (Select one if access is thru FCHN): [ ] First Health [ ] MultiPlan *(REQUIRED: Medical card with National wrap and FCHN 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 E-mail:

Employer Group Information

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

Run-in and Run-out Information

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

ADMIN ONLY

For Administrative Purposes Only (To be completed by Account Management)

Account Manager, PPO:	Receive Date:	Entry Date:

Notes:

Total Employees: