

EXHIBIT E
Group Benefit Plan Information Form

Per Section 2.2 of the Agreement Contract Holder shall provide group notification 30 days prior to implementation.

To: Account Management Department	Completed By: _____
First Choice Health PPO Network, Inc.	E-mail Address: _____
600 University Street, Suite 1400	Contract Holder: _____
Seattle, WA 98101	Telephone Number: _____
(206) 268-2485	Date Completed: _____
(206) 268-2942 Facsimile	

ID CARD(S) COPY (FRONT & BACK) ATTACHED

NEW PLEASE FILL OUT ALL FIELDS
 CHANGE PLEASE FILL OUT THE GROUP NAME, CHANGE (S) AND EFFECTIVE DATE OF CHANGE (S) ONLY
 TERMINATE PLEASE FILL OUT THE GROUP NAME AND EFFECTIVE DATE OF TERMINATION ONLY

GROUP INFORMATION

Group Name: _____ Effective Date: _____
 Group ID Number: _____ Number of Employees: _____
 WA _____ AK _____ ID _____ MT _____ OR _____

FCHN SERVICES

Network Access

FCHN Full Network (includes CAM Providers)
 FCHN Hospital only
 Complementary Alternative Medicine (CAM)
 (CAM providers include Acupuncturists, Massage Therapists, and Naturopathic Physicians)

Medical Management (MM)

MM Inpatient (IP)
 + Outpatient (OP) Surgery Global
 + Outpatient Surgery Targeted
 + Mental Health and Chemical Dependency (IP only)
 + Mental Health and Chemical Dependency (IP and OP)
 FCHN Case Management

MM Contact Information (must be provided):

Name: _____ Phone: _____

CLAIMS AND BENEFIT ADMINISTRATION

Benefits & Eligibility Provided By: _____
 Toll Free/Telephone Number: _____ Contact E-mail Address: _____
 Claims Submission Address as printed on identification card
 First Choice Health Network, Inc., PO Box 2289 Seattle, WA 98111-2289
 Claim Payor _____
 Other _____