

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 POAccountManagement@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)							
	<input type="checkbox"/> Full Network (All states)							
	<input type="checkbox"/> Oregon Access (Oregon)							
<input type="checkbox"/> Washington Access (Alaska, Idaho, Washington)								
<input type="checkbox"/> Montana Access (Colorado, Montana, Nebraska, North Dakota, South Dakota, Wyoming, Utah)								
<input type="checkbox"/> Custom Access (REQUIRED: Approval from Account Management)								
Add the Number of Employees (Complete the box for each state if applicable.)								
Alaska <input type="text"/>		Idaho <input type="text"/>	Montana <input type="text"/>	North Dakota <input type="text"/>	Oregon <input type="text"/>	South Dakota <input type="text"/>		
Washington <input type="text"/>		Wyoming <input type="text"/>	Colorado <input type="text"/>	Nebraska <input type="text"/>	Utah <input type="text"/>			
National Wrap (Select one if access is thru FCHN): <input type="checkbox"/> First Health <input type="checkbox"/> MultiPlan <i>(REQUIRED: Medical card with National wrap and FCHN logo)</i>								
Claim Submission / Benefits & Eligibility (For bold fields, refer to the group medical ID card)								
<input type="checkbox"/> 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)			
	<input type="checkbox"/> Full Network (All states)			
	<input type="checkbox"/> Oregon Access (Oregon)			
	<input type="checkbox"/> Washington Access (Alaska, Idaho, Washington)			
	<input type="checkbox"/> Montana Access (Colorado, Montana, Nebraska, North Dakota, South Dakota, Wyoming, Utah)			
	<input type="checkbox"/> Custom Access (REQUIRED: Approval from Account Management)			
National Wrap (Select one if access is thru FCHN): <input type="checkbox"/> First Health <input type="checkbox"/> MultiPlan <i>(REQUIRED: Medical card with National wrap and FCHN logo)</i>				
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):			
ADMIN ONLY	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:	
	For Administrative Purposes Only (To be completed by Account Management)			
Account Manager, PPO:		Receive Date:	Entry Date:	
Notes:				
			Total Employees:	