First Choice Health

Group Information Form

Email the completed form and a copy of the member ID card to PPOAccountManagement@fchn.com.

Both a copy of the ID card and the filled-out form are required for the submission to be considered complete.

Contract Holder Information

Contract Holder Name:		Date Submitting:
Contact Name:	Contact Phone #:	Contact Email:

Employer Group Information *(You are **required to include** a copy of group medical ID card with FCH logo)*

Group Name:	Group ID #:	City:	State:	Zip Code:	# of Employees:
Group Domiciled State:	Record the Effective Date or Term Date:	Indicate Date Type: ◯ Effective Date ◯ Term Date			

Network Wrap Access (**If you are using a national wrap through FCHN**, please indicate which one below)

☐ First Health ☐ Claritev (Multiplan) ☐ Prime Health ***REQUIRED: copy of group medical ID card with national wrap logo and FCH logo**

Claim Submission

Option 1: Submit to First Choice Health Network
Payor ID: 91131 PO Box 2289, Seattle WA 98111-2289

Option 2: Fill out the information below

Payor Name:	Payor Address:
Benefits & Eligibility provided by:	Benefits & Eligibility Phone:
Payor ID:	

Internal Office Use Only

Special Instructions:

Account Executive Name:	Date Submitted: