



DATE: _____

MEMBER INFORMATION

Member Name: _____ Contact Telephone: () _____
Group Name: _____

CHIROPRACTIC PROVIDER INFORMATION

Name: _____
Office Name (if applicable): _____
Office Phone: () _____ Office Fax: () _____
Office Address: _____
Street City State Zip code

ACUPUNCTURE PROVIDER INFORMATION

Name: _____
Office Name (if applicable): _____
Office Phone: () _____ Office Fax: () _____
Office Address: _____
Street City State Zip code

Upon receipt, our staff will contact the provider(s) listed above to see if they would like to join our network of participating providers. Please allow 4-6 weeks for recruitment efforts to be completed. Thank you for your nomination.

Submit Form by:
Mail: PhysMetrics P.O. Box 25220 Fresno, CA 93729-5220
Fax: 888.439.4819
Call: 877.519.8839
Email: info@physmetrics.com