

NLPHO / AETNA & COVENTRY MEDICARE ADVANTAGE PLANS ENROLLMENT FORM

Reimbursement will be 100% of current Medicare

- ☐ I **DO** wish to participate in the Aetna & Coventry Medicare Advantage networks through NLPHO.
- ☐ I do **NOT** wish to participate in the Aetna & Coventry Medicare Advantage networks through NLPHO.

I am currently accepting new Medicare patients:

☐ Yes

☐ No

Group Practice Name (please print)

Provider (or Authorized Signature)

Federal TIN #

Date

Please list provider names (for this contract: **MDs, DOs, NPs, PAs, PTs, OTs, SLPs, & CRNAs**):

Provider Name (please print)

Provider Name (please print)

Provider Name (please print)

Provider Name (please print)

Provider Name (please print)

Provider Name (please print)

Provider Name (please print)

Provider Name (please print)

Provider Name (please print)

Provider Name (please print)

Provider Name (please print)

Provider Name (please print)

Please sign this form and return by:

Fax to (318) 387-7452 / Email to monica.pittman@fmolhs.org Or mail to:

Northeast Louisiana Physician Hospital Organization

1900 North 18th Street, Suite 304, Monroe, LA 71201

Call (318) 387-7358 with questions
