Blue Cross and Blue Shield of Georgia Provider Nomination Form

If your physician is not currently part of Blue Cross and Blue Shield of Georgia's (BCBSGa) network of doctors, and you would like your physician to be considered for the network, please follow the four steps indicated below:

1. Complete and fax the form to **877-551-6184**. Or email it to **providersupport@bcbsga.com**.
2. After initial prescreening, the physician may be sent an application for network participation.
3. The application process is not immediately following receipt of your physician's information. Acceptance into the BCBSGa network is contingent upon successful completion of our credentialing process and provider acceptance of our contracts.*
4. If you have any questions regarding the status of the application, please contact your physician directly.

*Members may nominate providers for participation in the network by submitting this nomination form to BCBSGa. Nomination **does not** guarantee the provider will be added to the BCBSGa network.

REFERRING MEMBER INFORMATION			
Last Name		First Name	
E-Mail		Phone Number	
Employer's Name			
PROVIDER INFORMATION			
Last Name		First Name	
Is he/she a Primary Care Physician ☐ YES ☐ NO			
Primary Specialty		Secondary Specialty	
Practice or Group Name			
Street Address			
City	State	Zip Code	County
Phone Number		Fax Number	

Fax this completed form to:
Blue Cross and Blue Shield of Georgia
Attn: Provider Nomination
Fax: **877-551-6184**

Or email it to: **providersupport@bcbsga.com**