HEALTH OHIO NETWORK
(HON)

Physician Membership Request Form

If your physician is currently not a HON Preferred Provider, you may wish complete the following form and return it to us at the address listed below. The provider named will then receive application information for review.

**Please note that not all physicians meet qualifying criteria and that not all physicians wish to become a Preferred Provider.

Please Print

Physician's Name: ____

Street Address: ____

City: _________________________________State: _____________ Zip Code: ________

Telephone Number: Area Code (______) _____________________________________

Specialty: ____

Hospital Affiliation: ____

Are you currently using this Provider/Facility? ____________________

Please Print

Your Name: ____

Your Address: ____

City:_________________________________**State**: _____________**Zip Code**:________

Email Address: ____

Place of Employment: ____

My name may be used when contacting the Physician: Yes _____ No_____

Return to:

Health Ohio Network, LLC.
P.O. Box 848
Hudson, Ohio 44236
Attn: Customer Service
Phone: 234-380-5700 Fax: 234-380-5774
CustomerService@HealthOhioNetwork.com