



Customer Care: 877-870-0638

Fax: 214-217-5937

Toll Free Fax: 877-946-6638

IMO Med-Select Network[®] Provider Nomination Form

Date:

Submitted by whom:	
Mailing Address (street, city, state, zip code)	
Telephone Number:	Fax Number:
Email Address:	

If you currently have a referral preference for other medical providers such as physician specialist, physical or occupational therapist, etc, please feel free to provide other possible providers for our network below.

Physician Name	
Specialty	
Mailing Address (street, city, state, zip code)	
Telephone Number:	Fax Number:
Email:	

Physician Name	
Specialty	
Mailing Address (street, city, state, zip code)	
Telephone Number:	Fax Number:
Email:	

Physician Name	
Specialty	
Mailing Address (street, city, state, zip code)	
Telephone Number:	Fax Number:
Email:	

Fax form to : 214-217-5937 or 877-946-6638

Nomination for the IMO Med-Select Network[®] does not guarantee automatic approval, additions are based on physician specialty and demographic needs. All physicians and ancillary providers must meet Network credentialing requirements, contractual requirements and accept workers' compensation.