Provider Nomination Request

PO Box 91110
Sioux Falls, SD 57109
(605) 328-6800 • 1-800-752-5863
Fax: (605) 328-6840
sanfordhealthplan.com

SANFORD HEALTH PLAN

Please complete this form if you would like Sanford Health Plan to contact a provider for participation in the Sanford Health Plan network. Although we cannot guarantee that a provider will choose to participate, we will contact them. We encourage you to follow up with the provider as well.

Please fax the completed form to (605) 328-7224 attention Provider Relations or scan and email it to ppr@sanfordhealth.org.

Provider Information *(please print)*:

Last Name First Name Middle Initial

Primary Specialty Degree/License (e.g. M.D., P.A., L.P.C.)

Clinic/Facility Name

Clinic/Facility Mailing Address City State Zip

Clinic/Facility Phone

Member Information *(please print)*:

Last Name First Name Middle Initial

Member ID# Date of Birth

Home Mailing Address City State Zip

Phone Email

If your dependents see this provider, please print their names: _____

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