



Provider Nomination Form

Maryland Physicians Care is interested in providers you would like to see in the Maryland Physicians Care Provider Network. Please complete the information below and fax or mail in your submission.

Date: _____

Physician Name: _____

Medical Group Name (not required): _____

Address/Telephone Number (required): _____

Please provide some information about yourself. Thank you for nominating a provider/facility.

Your Name: _____

Daytime Telephone: _____

Evening Telephone: _____

Email address (not required): _____

FAX to:
Maryland Physicians Care at (866) 724-2249

Mail to:
Maryland Physicians Care
Attn: Provider Relations Department
509 Progress Drive, Suite 117
Linthicum, MD 21090-2256