TRISTAR Managed Care
Provider Nomination Form

INSTRUCTIONS
Please complete the form below and fax it to the Medical Network Administrator at (714) 245-4856 or mail to TRISTAR Managed Care Attn: Medical Network Administrator P.O. Box 10220 Santa Ana, CA 92711. A decision will be made within 30 days of receipt of this request.

I. Requestor Information (If Injured Employee – Please fill out Date of Injury, Date of Birth, SSN and Claim Number)

First:		Last:		MI:		Date of Injury:	
Date Of Birth:		SSN:		Claim Number:			

Address:		City:	
		State:	
		Zip:	
		County / Parish:	

Phone:		Fax:		Email:	

II. Provider Information

Provider Name:	
Provider Group (if applicable):	

Address:		City:	
		State:	
		Zip:	
		County / Parish:	

Phone:		Fax:		Email:	

III. Reason for Nominating Provider

Explain Why You Are Nominating this Provider (Attach additional sheets if necessary.):

****If you are provider submitting a self-nomination, please complete the appropriate group or individual credentialing application found online at www.tristarmanagedcare.com or contact the Medical Network Administrator at TMC.PPO@tristargroup.net or (877) 287-4782 x.1441 for more information.