American Behavioral ®

Provider Nomination/Addition Form

American Behavioral strives to maintain the best provider network for its client organizations, their employees and family members. If you have a provider or providers you would like to nominate for possible inclusion in the American Behavioral network, please fill out this form and fax it to 205-868-9625. This is a confidential process.

Select one: ☐Psychiatrist ☐ Psychologist ☐ Therapist

Nominated by: ☐ Self ☐ Member or Dependent ☐ HR Representative

Provider Name: ____

Provider Address: ____

City: ______________________________ **State:** _________ **Zip:** _____________

Provider Telephone Number: (_____)____________________Email:______________________

Provider Specialty (Check All That Apply):

☐ **Adult** ☐ **Adolescent** ☐ **Children** ☐**Geriatric**

☐ **Other (i.e. Substance Abuse, ADHD, Mood Disorders, Etc.)**

____

Facility

Facility Name: ____

Facility Address: ____

Facility Main Telephone Number: (__________)_____________________________

Facility Specialty:

☐ **Substance Abuse** ☐ **Mental/Nervous**

☐ **Inpatient** ☐ **Partial Hospitalization** ☐ **Intensive Outpatient** ☐ **Residential**

Other:____

Name of person nominating provider (optional):______________________________

Client Company Name:____