



PROVIDER NOMINATION FORM

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

Date: ____/____/____

Physician Name: _____

Medical Group Name (if known): _____

Address (Required): _____

Telephone Number: (Required): (____) _____

Provider Specialty: _____

Information about YOU. Thanks for nominating a provider/facility

Your Name: _____

Daytime Telephone: (____) _____

Evening Telephone: (____) _____

Email Address: _____

Fax to: (813) 775-0682

or

Mail to: Integral Quality Care
4630 Woodland Corporate Blvd.
Tampa, FL 33614