



Referral Letter Program at Private Healthcare Systems

If you would like to invite your health care provider to join the **PHCS Network**, you may do so by presenting him or her with this referral letter. If interested, your provider will forward the attached card to PHCS for consideration. If your provider meets our credentialing and other participation requirements and becomes a provider in the **PHCS Network**, you may be eligible to receive a higher level of benefits from your health plan when you use this provider.

How Does This Program Work?

Take this referral letter directly to your provider. If your provider is not in the **PHCS Network**, he or she can call the PHCS Member and Provider Services line at (800) 950-7040 to request an application or may complete and return the reply card below.

Your provider will then receive an application packet for completion and forwarding to PHCS. All providers must meet PHCS requirements for Network participation. In order to be eligible for a higher level of benefits, please be sure to verify that your provider has been accepted into the **PHCS Network**. You may check with your provider's office for a status update.



NO POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES

BUSINESS REPLY MAIL
 FIRST-CLASS MAIL PERMIT NO. 7139 BOSTON MA

POSTAGE WILL BE PAID BY ADDRESSEE

Private Healthcare Systems Inc.
 Member and Provider Services Department
 1100 Winter Street Ste 3800
 Waltham MA 02451-9368







Dear Provider:

My health insurance includes medical services accessed through the **PHCS Network**. Through this arrangement I may be able to receive maximum benefits by visiting in-network providers. I would like you, as my provider, to consider participating in the **PHCS Network**, so that I can take advantage of this opportunity.

Please complete and mail the attached postage-paid card or complete the online request form located in the Provider section of www.phcs.com. PHCS will then send information to you about joining the Network.

Sincerely,

Patient's signature

Patient's name: _____

Address (optional): _____

Phone (optional): _____

Please send me more information about participating in the **PHCS Network** of providers. My practice information is listed below:

Provider's Name: _____

Specialty: _____

Hospital Affiliation(s): _____

Provider's Address: _____

Phone #: () _____

Office Manager's Name: _____