

BestComp, Inc.

Provider Nomination Form

If you would like to nominate a provider for participation in BestComp, Inc., please complete the following form and fax it to us at 225-755-5702.

1. Your Information:

Your Name: _____

Employer: _____

Address: _____

City: _____

State: _____

Zip: _____

Phone Number: _____

Email Address: _____

2. Doctor's Information

Last Name: _____

First Name: _____

MI: _____

Primary Specialty: _____

Address: _____

City: _____

State: _____

Zip: _____

Office Phone: _____

Comments: