



## **Referral Letter Program at Creenaght**

If you would like to invite your health care provider to join the Creenaght network, you may do so by presenting him or her with this referral letter. If interested, your provider will forward the attached card to Creenaght for consideration. If your provider meets our credentialing and other participation requirements and becomes a provider in the Creenaght 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 Creenaght Network, he or she can call the Creenaght Member and Provider Services line at (866) 824 0228 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 Creenaght. All providers must meet Creenaght 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 Creenaght Network. You may Network check with your provider's office for a status update.

Creenaght L.L.C.  
Member and Provider Services Department  
18958 Coastal Highway  
Suite B  
Rehoboth Beach, DE, 19971

Dear Provider:

My health insurance includes medical services accessed through the Creenaght 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 Creenaght Network, so that I can take advantage of this opportunity.

Please complete and mail the attached page. Creenaght 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 Creenaght Network of providers. My practice information is listed below:

Providers Name: \_\_\_\_\_

Specialty: \_\_\_\_\_

Hospital Affiliations:

\_\_\_\_\_

\_\_\_\_\_

Providers Address:

\_\_\_\_\_

\_\_\_\_\_

Providers Phone: \_\_\_\_\_

Office Managers Name: \_\_\_\_\_