Request to Contract Form

Provider/Group/Business Information	Reimbursement (Where Payment is sent)
Business Owner:	Provider/Group Name/DBA:
Provider/Group Name/DBA:	Mailing Address:
TAX ID:	City/State/Zip Code:
Provider NPI:	Telephone:
Group NPI:	Fax:

The Provider/Group Name/DBA and address must match Box 33 of the HCFA 1500 Form.

Practice Information

Number of Providers (MD, DO, PA-C, NP-C): ____________________ Practice Specialty: ____________________

Number of Locations: ____________________ Website: ____________________

Attach a reference sheet that includes the following:	*All Provider Information*	*All Location (s) Information*
	Provider (s) Full Name	Address
	Credentials (Degree)	Phone and Fax Numbers
	Mobile Number	Office Manager
	Hospital Affiliations	Office Hours
		Languages Spoken

Department Point of Contact Information

Department	Name	Title/Business	Telephone	Fax	Email
Communication Updates (see below)					
Credentialing/Contracting					
Billing					
Referral/Prior Authorization					

Communication Preference

Administration Updates	❑ Email	❑ Fax	❑ Other:____________________
Clinical Updates	❑ Email	❑ Fax	❑ Other:____________________
Newsletters	❑ Email	❑ Fax	❑ Other:____________________
Provider Communication Bulletin	❑ Email	❑ Fax	❑ Other:____________________
Meeting Invitations	❑ Email	❑ Fax	❑ Other:____________________

Onsite Radiology? ❑ Yes ❑ No — If yes, specify services/Managing Company? ____________________

Onsite Laboratory? ❑ Yes ❑ No — If yes, specify tests/Managing Company? ____________________

Appointment Scheduling: ❑ Onsite ❑ Central

EMR System: ❑ Yes ❑ No — If yes, Provide the Name. If No, provide the time frame in which you will integrate an EMR. ____________________

What system does your practice use to transfer Medical Records to other Specialists/PCP's/Hospitals? ❑ Yes ❑ No — If yes, Provide the Name: ____________________

Does your Practice participate with an electronic prescription software? ❑ Yes ❑ No — If yes, Provide the Name: ____________________

Would you be interested in linking with P3 Health Partners System? ❑ Yes ❑ No

Does your Practice accept Medicaid members? ❑ Yes ❑ No — If so, how many Medicaid Members does your practice have? ____________________

Does your Practice accept Medicare members? ❑ Yes ❑ No — If so, how many Medicare Members does your practice have? ____________________

Provider/Group/DBA Signature

I attest that to the best of my knowledge the information I have provided is complete and accurate.

____________________ ____________________

Print Name Date

____________________ ____________________

Signature Date

Please complete this form and return it to to P3 Health Partners' Network and Contracting Department. The processing of this information is based on the completion and accuracy of the information provided above. Along with this form, please attach your W-9, HCFA 1500 with boxes 25,31, and 33 completed.