LEON MEDICAL CENTERS HEALTH PLANS HEALTHSPRING

NETWORK INTEREST PROFILE FORM

FAX Completed Profile Form To: Network Operations – (305) 646-3781

General Information

Corporate Name: Date: / /

Contact Person: Phone #: Email:

Form Completed By: Phone #: Email:

Operating Name *(DBA)*: Tax ID#

Medicare #: NPI#: Medicaid #:

Provider Physical Location:

Multiple Locations? ☐ Yes ☐ No ***If yes, please attach additional location information***

Provider Specifications

Please check the type(s) of services you provide:

☐ Acute/Hospital ☐ LTAC

☐ Dialysis ☐ DME ☐ Home Health ☐ Infusion

☐ SNF ☐ Ambulatory Surgery Center ☐ PT OT ST ☐ Orthotics/Prosthetics

☐ Urgent Care ☐ Other: _____ ☐ Behavioral Health FAC

☐ Diagnostic *(specify services- i.e. lab, radiology, MRI)*: _____

Are you accredited? ☐ Yes ☐ No ***If yes, list the accrediting entity:***

Do you carry general and professional liability insurance? If so, how much? ***General:*** ***Liability:***

Providers must be a licensed Medicare approved provider to be considered for our Medicare Advantage product. Please circle the states that you service and list or attach a list of counties:

Alabama **Mississippi** **Florida** **Tennessee** **Illinois** **Texas**

_____

_____

Are you interested in servicing in multiple states? ☐ **Yes** ☐ **No**

If yes, please attach additional information on servicing states

HealthSpring Use Only

☐ Existing ☐ HealthServices ☐ Customer Service ☐ Credentialing

Comments: *(GAP or market expansion)*

Approved By	Inquiry Denied
☐ NetOps ☐ Other	Denial letter sent date: _____/_____/_____
Signature:_____	Signature:_____
Title/Dept: _____	Title/Dept:_____
Date:_____/_____/_____	Date:_____/_____/_____

Your request will be presented at HealthSpring's Network Review Committee meeting; you will be notified once a decision is rendered. Determinations are based on network need and current availability of services. PLEASE NOTE: Requesting, obtaining, or submitting a profile form does not guarantee or imply that you will be accepted to participate in the HealthSpring network, nor does it entitle you to payment of any services rendered to a HealthSpring member prior to receiving written confirmation of an effective date and meeting any and all applicable authorization requirements. All providers are subject to HealthSpring credentialing requirements and applicable state and federal guidelines as set forth in the HealthSpring participating provider agreement.

Address **Local:** **Toll Free:** **Fax:**