REQUEST FOR APPLICATION

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

Contact Person: ______________________________ Phone: ____________________

Fax #: __________________ E-Mail Address:____________________________

Is this an enrollment service? No Yes If yes, please list name: ____________________

Requesting Application for:

Provider Name: ______________________________ Professional Title: __________
Desired Role: Primary Care Physician Specialist Other ____________________

Practicing Specialty: ____________________ Board Certified: Yes No

Admitting Hospital (s): ____

If provider is a PCP and has no admitting privileges, will the provider use:
Hospitalist Another Physician – Name/Specialty:____________________________

NPI: __________________ Medicare #:_________ Tax ID Number:_________________

Practice Model: Solo Group Number of physicians in group: _____
Name 2 members:_________________________

Group or Practice Name:____________________________ Multiple Locations: Yes No

Office Address:____________________________________City:________________

State:_______ Zip Code:________ County: ________________

Mark box: Send application via: Mail Fax E-Mail

Mailing Address, if different from office address:

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For HealthSpring Use Only:

Rec'd:	Send Application & Contracts (all products) Send Application Only (group contract candidate) Send Contract Only (provider in SHA network)	Date Packet Mailed:
Rev'd (Initials):	HS Fee Schedule:	
Application Request Denied	Reason Application Request Denied:	Date Denial Letter Sent:
Access Posting Completed	Date:	Initials: