

**Application Request**

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| **Thank you for your interest in joining MultiPlan’s Medicare Advantage provider network.** To complete this form, first save it to your computer, complete the required fields, save the form and then send it to MultiPlan at the following email address: GBSNominations@multiplan.com. We will begin processing your form and an application packet will be mailed to you shortly. If you have questions about completing this form, call our Service Operations team at 866-971-7427. \* = required fieldProvider Type |
| Individual practitionerAcute care facility such as a hospitalAncillary facility such as a lab, rehab or hospiceRural Health Clinic (RHC) Federal Qualified Health Center (FQHC) | Group - less than 25 practitionersGroup - 25 or more practitioners Ambulatory Surgery Center Behavioral Health Critical Access Hospital |
|   |
| Provider Information |
| Please include your middle initial. |
|   |
| First Name\*: |  | Middle Initial: |  |
| Last Name\*: |  | Suffix: |  |
| Group / Facility / Practice Name\*: |  |
| Gender\*: | Male Female |
| Email: |  |
| Phone\*: |  Ext: |
| NPI #: |  |
| TIN: |  |
| Medicaid #: |  | Medicare #: |  |

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| Primary Service Address:  |
| Firm Name: |  | Attention: |  |
| Address Line 1\*: |  |
| Address Line 2: |  |
| City\*: |  | State\*:   Zip Code\*:  |
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Provider Information, *continued*

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| Mailing Address (*if different from service address*):  |
| Address Line 1: |  |
| Address Line 2: |  |
| City: |  | State:   Zip Code:  |

Questionnaire

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| Are you a hospital based provider?\* | Yes No  |
| What is your primary specialty?\* | Choose an item. |
| What is your highest degree?\* | Choose an item. |
| Do you, or someone on your behalf, have admitting privileges to a hospital that participates in any of the MultiPlan networks (PHCS Network, MultiPlan Network or PHCS Savility)?\* | Yes No |
| Is there a participating hospital within 25 miles of your primary practice location?\* [Search](http://www.multiplan.com/search/search-1.cfm) | Yes No |
| Do you accept direct referrals for patients?\* | Yes No |
| Do you practice in more than one state?\* | Yes No |

Additional Information:

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| Is there someone we can contact regarding this application request? |
| Name: |  |
| Phone: |  Ext:  |
| Contact Person, Best Time to Call or Additional Comments |