Genesee Health Plan
Your Plan for *Better Health*

PROVIDER REQUEST TO CONTRACT FORM

Complete the information below, sign and return form with W-9

Provider Type: **Primary Care** **Specialist** **Allied Health** **Ancillary**

Degree: **MD** **DO** **DPM** **OD** **PA** **NP** **OTHER**

PHYSICIAN INFORMATION

Name (last, first, middle initial):

NPI Number: **Male** **Female**

CAQH ID Number:

Specialty:

Does your practice participate in Medicare? **YES** **NO** **Medicaid?** **YES** **NO**

If Primary Care, accepting new patients? **YES** **NO**

Joining Existing Practice? **YES** **NO** *If yes, name of practice:*

PRIMARY OFFICE INFORMATION

Contact Person: **Email:**

Street address: **Suite #:**

City: **State:** **Zip:**

Office Phone: **Fax:**

Hospital System Affiliation: McLaren Flint Hurley Ascension Genesys

Other:

BILLING INFORMATION

Bill To Name: **Billing Contact Person:**

Billing street address: **Suite #:**

City: **State:** **Zip:**

Office Phone: **Fax:** **Email:**

Tax ID Number: **Current W-9 included?** **Yes** **No**

CONSENT AND AUTHORIZATION

By signing this form, I affirm that the information provided is true and accurate to the best of my knowledge. Any incomplete or misstatements could result in denial of contracting. I also authorize GHP to access physician information from the Council of Affordable Quality Healthcare (CAQH) Proview database.

Signature:______________________________ Date:______________________________

Printed name:______________________________ Title:______________________________