

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	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	Henry Ford - 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: _____		