

**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](mailto: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 field  Provider Type | | | | | | | | |
| Individual practitioner Acute care facility such as a hospital Ancillary facility such as a lab, rehab or hospice Rural Health Clinic (RHC)  Federal Qualified Health Center (FQHC) | | Group - less than 25 practitioners  Group - 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\*: | | |
|  |  | | | |

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:

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