

## REQUEST FOR APPLICATION

FAX Completed Request Form To:				
Contact Person:		Phone:		
Fax #:	E-Mail Addre	ss:		
Is this an enrollment service?	No Yes If yes, please list name:			
Requesting Application for:				
Provider Name:			Professional Title:	
Desired Role: Primary Care	e Physician			
Practicing Specialty:			Board Certified: Yes No	
Admitting Hospital:				
-	admitting privileges, will the provider use:			
NPI:	Medicare #:	_ Tax ID Nu	ımber:	
Practice Model: Solo Group Number of physicians in group:		Name 2 members:		
Group or Practice Name:			Multiple Locations:	
Office Address:		City:		
State:	Zip Code:	County: _		
	a Mail Fax E-Mail			
	Attn:			
For HealthSpring Use O	nly:			
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:	