REQUEST FOR PARTICIPATION

Return to Health Choice Utah Network Services Department: Fax (801) 758-3120

Please complete entire form. (COMPLETE ONE SHEET PER LICENSED PROFESSIONAL)

REASON FOR APPLYING (Attach Nominations): _____

CONTACT NAME AND NUMBER: _____

PROVIDER NAME: _____

PROVIDER NPI: _____

PROVIDER SPECIALTY(IES): _____

PROVIDER BOARD CERTIFICATIONS: _____

PRACTICE NAME: _____

PRACTICE ADDRESSES (attach additional): _____

CITY, STATE, ZIP: _____

OFFICE PHONE: _____

OFFICE FAX: _____

OFFICE HOURS: _____

BUSINESS EMAIL: _____

ARE YOU REGISTERED WITH UTAH MEDICAID: **Y**☐ / **N**☐

DO YOU PARTICIPATE WITH MEDICARE: **Y**☐ / **N**☐

PROVIDER'S GENDER ☐M ☐F PROVIDER'S LANGUAGES: _____

GENDER(S) ACCEPTED ☐M ☐F PT AGE RANGE ☐0-99 ☐0-16 ☐0-18 ☐18-99 ☐21-99 ☐OTHER: _____

STAFF LANGUAGES: _____ # MEMBERS WHO CAN BE ACCOMMODATED BY PRACTICE _____

HOSPITAL PRIVILEGES, PRIVILEGE STATUS, AND % OF ADMISSIONS TO EACH HOSPITAL:

_____

COVERING PHYSICIANS: _____

TOTAL NUMBER OF PHYSICIANS AND OTHER LICENSED PROFESSIONALS (FOR GROUPS): _____

Health Choice Internal Use Only (DGHNA):