

HEALTH | CHOICE

UTAH

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: _____ CAQH # _____

PROVIDER NPI: _____ PRACTICE NPI: _____

PROVIDER SPECIALTY(IES): _____

PROVIDER BOARD CERTIFICATIONS: _____

PRACTICE NAME: _____ Practice TIN: _____

PRACTICE ADDRESSES (attach additional): _____

CITY, STATE, ZIP: _____

OFFICE PHONE: _____ Office Fax: _____

OFFICE HOURS: _____

BUSINESS EMAIL: _____

**** Please make sure CAQH is up to date with current information. Credentialing could be delayed if not current.**

ARE YOU REGISTERED WITH UTAH MEDICAID: Y / N Provider Medicaid # _____

DO YOU PARTICIPATE WITH MEDICARE: Y / N Provider Medicare # _____

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):