Request for new provider ☐ **Change to an existing provider** ☐

Members HEALTH INSURANCE

Professional Providers:

Last Name/Generation/Degree: _____ _____ _____

First Name/Middle Initial: _____ _____

Practicing Specialty: (**Required**): _____

NPI Number: _____ State License Number & Issue Date (**REQUIRED**)_____

Race and/or National Origin (Optional): ☐White ☐Black ☐Hispanic ☐Asian or Pacific Islander ☐American Indian/Alaskan Native ☐Other
Gender: ☐Male ☐Female

Ancillary or Facility Providers:

Provider Name: _____

NPI Number: _____ State License Number & Issue Date (**REQUIRED**)_____

Type of Provider:

____Acute Care Hospital	____Ambulatory Surgical Facility	____Durable Medical Equipment
____Home Health Agency	____Home Infusion Therapy	____Hospice
____Inpatient Rehab Facility	____Specialty DME	____Laboratory
____Medical Supplies	____Pharmacy	____Skilled Nursing Facility
____Outpatient Rehab Facility	____Kidney Dialysis Center	____Other _____

Demographic Information:

☐Primary Location ☐Secondary Location

Physical Practice Location (**No P. O. Boxes, please**)

_____

_____

_____

Date Began Practicing at this location: (**REQUIRED**) _____

Is your office handicap-accessible? ❑Yes ❑No

Mailing / Correspondence Address:

(mail other than checks and EOPs should be sent to this address)

☐ same as office address

☐ same as billing

☐ other _____

_____

Office Hours: _____

Office Telephone Number: _____

Fax Number: _____

Payments:

Make checks payable to:

☐ Payments should be made for individual provider?

☐ Roll payments up to single check for all providers in the group?

Group Name, if applicable:_____

Group Name, if applicable:_____

Group/Organization NPI Number:_____

Pay To Address:_____

_____

IRS (W-9) Name: _____

IRS (W-9) Address: _____

_____

TIN # ***or*** SSN # (for tax purposes): _____

Professional Providers only, please complete the following:

Social Security Number: (**REQUIRED**): _____

Date of Birth:_____

Languages Spoken:_____

Medicare Number:_____

DEA Number:_____

Are you a Hospital-Based Provider ☐Yes ☐No

Contact Name: _____ Title: _____ Phone: ( ) _____ Email:_____

Practitioner or Office Manager Signature: _____ **Date**_____: _____

If you have questions or need assistance please call **1-888-708-0123.**
Please email the completed form(s) to providers@mhinsurance.com or fax the completed form(s) to (931) 560-4278.