

Contracting Request Form

Plan de Salud Menonita

I. Line of Business		
<input type="checkbox"/> Commercial	<input type="checkbox"/> Vital	
II. Billing Information		
Legal Name:		
Doing Business As:		<input type="checkbox"/> N/A
Billing Tax Id or Social Security Number:	Billing NPI Number:	
Billing PEP/PRMMIS Number:	Billing Email:	
Billing Phone Number:	Billing Fax Number:	<input type="checkbox"/> N/A
Mailing Address:		
Pay To Address:		
III. Rendering Information		
Legal Full Name (If Individual please include Full Name(s) and both Last Name)		
Doing Business As:		<input type="checkbox"/> N/A
Specialty:	<input type="checkbox"/> Adult <input type="checkbox"/> Pediatric	Date of Birth (mm/dd/yyyy) <input type="checkbox"/> N/A (No Practitioners)
Practitioner or SARAF License Number:		
Rendering Tax Id or Social Security Number:	Rendering NPI Number:	
Rendering PEP/PRMMIS Number:	Provider Email:	
CLIA Number:	<input type="checkbox"/> N/A	Do you provide Telemedicine Service? <input type="checkbox"/> YES <input type="checkbox"/> NO
IV. Rendering Practice Locations		
Primary Location Address		
Please Identify Location Type:		
<input type="checkbox"/> Private Practice	<input type="checkbox"/> Group Practice/ Clinic	
<input type="checkbox"/> Hospital Based Physician	<input type="checkbox"/> Medical Clearance	
Accept New Patient in this Location? <input type="checkbox"/> YES <input type="checkbox"/> NO	Is this Location Registered in PEP/PRMMIS? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Physical Address:		
City:	State:	Zip + 4 Code
Phone Number:	Alt Phone Number:	Service Hours (Days and Hours):

Secondary Location Address: <input type="checkbox"/> N/A		
Please Identify Location Type:		
<input type="checkbox"/> Private Practice	<input type="checkbox"/> Group Practice/ Clinic	
<input type="checkbox"/> Hospital Based Physician	<input type="checkbox"/> Medical Clearance	
Accept New Patient in this Location? <input type="checkbox"/> YES <input type="checkbox"/> NO	Is this Location Registered in PEP/PRMMIS? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Physical Address:		
City:	State:	Zip + 4 Code
Phone Number:	Alt Phone Number:	Service Hours (Days and Hours):
Third Location Address: <input type="checkbox"/> N/A		
Please Identify Location Type:		
<input type="checkbox"/> Private Practice	<input type="checkbox"/> Group Practice/ Clinic	
<input type="checkbox"/> Hospital Based Physician	<input type="checkbox"/> Medical Clearance	
Accept New Patient in this Location? <input type="checkbox"/> YES <input type="checkbox"/> NO	Is this Location Registered in PEP/PRMMIS? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Physical Address:		
City:	State:	Zip + 4 Code
Phone Number:	Alt Phone Number:	Service Hours (Days and Hours):
V. Signature Authorized Official		
Authorized Official Name:	Authorized Official Signature:	
Authorized Official Signature Date:	Authorized Official Email:	