Please save a copy of document to your computer and *Enable All Features* to complete the form

PROVIDER LETTER OF INTEREST REQUEST

Type of request: NEW ☐ Primary care provider contract ☐ Ancillary/specialist contract ☐ Add line of business

Desired lines of business: ☐ Medicare HMO ☐ Medicare PPO ☐ Medicaid

Legal practice name:

Federal tax identification number:

Include copy of the group W-9: Attach W-9 to email

Group National Provider Identifier (NPI) number:

Group Medicaid number (only if requesting Medicaid):

Primary practice specialty: Other If other, type specialty here

Provider names and NPI number: (If you have additional providers, please attach a roster.)

Name	Individual NPI	CAQH	Specialty	Individual Medicaid number (if req Medicaid)
			Other	
			Other	
			Other	
			Other	
			Other	

Primary location: County Office phone No. Office fax No.

Provider contact name and email:

Office days/hours:

Hospital privileges:

Do you have additional locations? Select How many? (Attach additional locations)

Billing information (if different from primary location address):

Billing name:

Billing address: Phone: Fax:

Additional information:

How long has your practice been providing services within the marketplace? Years Months

What differentiates your office from other practices in your specialty?

Review of request does not constitute or guarantee a contract will be issued or executed between both parties.

What other payers are you contracted with?

Do you have any current or previous affiliation to a Value-Based provider (existing contracted provider with Humana)?

What is your current practice size? (i.e., number of Medicare, Medicaid members)

What is the patient age range at your practice?

Have you performed any of the following services in your office?

☐ Radiology ☐ Ultrasounds ☐ Lab services ☐ PT/OT/ST ☐ Chiropractic services ☐ Optometry

☐ Podiatry ☐ Pain management ☐ Others (list)

Do your providers perform services at any ambulatory surgery centers (ASCs)? If so, please list:

Who in your practice is the authorized contract signatory? (Please provide their name, title and email.)

For official contract notifications, what is the address for notices?

Urgent care centers only

Has a national urgent care organization accredited your facility? ☐ Yes ☐ No

If not, do you have plans to apply for this type of accreditation? ☐ Yes ☐ No

Are there any intentions of conversations? ☐ Yes ☐ No

What is the approximate daily volume of patients seen in the facility?

Ambulatory surgery centers (ASC)

Ownership details *Please check one below or explain if "other."*			
Physician owned ☐	**Hospital owned☐**	**Independently owned ☐**	**Other ☐**
Additional ownership details *Please provide with name(s) or explain below as applicable.*			
List name of ownership entity/physician:			
Please answer the following questions regarding your ASC:			
What is the closest hospital to the ASC?			

What surgical services are performed at your ASC?
(*Provide a list below to include codes and descriptions or include as a separate attachment.*)

Surgical services provided at ASC

Surgical services	Surgical service descriptions	Code

Facility-based professional information
(*Please read the statement and check the appropriate answer below.*)

Statement	**Yes**	**No**
Do you provide your own employed anesthesiologists?	☐	☐
Do you bill separately for anesthesia services?	☐	☐
Do you have any assistant surgeons employed by the ASC?	☐	☐
Do you have any pathologists employed by the ASC?	☐	☐
Do you have any radiologists employed by the ASC?	☐	☐

*If you answered **no** to the above questions, please include who you utilize for these services below and specify their company name, TIN and NPI numbers. Please add separate document with this information if you utilize multiple providers.*

Billing and claims
(*Please read the statement and check the appropriate answer below.*)

Statement		
How do you bill (submit claims)?: POS 11 or POS 24? *Please check your response on the right.*	☐ **POS 11**	☐ **POS24**

Additional ASC questions
(*Please read the statement and check the appropriate answer below.*)

Do you provide implants for any surgeries?	Yes ☐	No ☐
If **yes** to providing implants, specify to the right where you get the implants. (Please include company name, etc.)		
******Please attach a copy of the implant invoice for the implant(s) provided.***		
If **yes**, specify to the right where you get the orthotic? (Please include company name, etc.)		
Does your facility have the ability to perform cardiac catheterization?	Yes ☐	No ☐
Does your facility perform cardiac catheterization with ablation?	Yes ☐	No ☐
Does your facility perform colonoscopies?	Yes ☐	No ☐