



# PROVIDER CONTRACT REQUEST FORM

**PLEASE COMPLETE THIS FORM, ALONG WITH A COPY OF YOUR W9, AND FAX TO:**

**MHP-CONTRACTING DEPARTMENT @ 866-480-3227**

**PLEASE INDICATE YOUR PROVIDER TYPE – Choose all that apply:**

<input type="checkbox"/> Physician: (MD, DO, DMD)	<input type="checkbox"/> Hospital	<input type="checkbox"/> Ambulance
<input type="checkbox"/> Practitioner: (FNP, CRNA, etc.)	<input type="checkbox"/> Hospice	<input type="checkbox"/> Surgical Center
<input type="checkbox"/> Clinic- FQHC, RHC, Other	<input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> ST	<input type="checkbox"/> Other _____
<input type="checkbox"/> Diagnostic Imaging Center	<input type="checkbox"/> Rehabilitation Center	
<input type="checkbox"/> Dialysis Center	<input type="checkbox"/> Skilled Nursing Facility	

**PROVIDER INFORMATION**

Practice Name or Clinic/Hospital Name:		
Street:	City/State/Zip	Phone:
Contact Person/Title:	Fax:	E-Mail:
Hours of Operation: Mon _____ Tues _____ Wed _____ Thurs _____ Fri _____	County:	Medicaid #:
Notes/Comments:	National Provider Identifier (NPI)#:	TIN #: