

**Letters of Interest Contract Request Form**

Name of Interested Provider or Provider Group: \_\_\_\_\_

Practice Address:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Billing Address:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Phone Number: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Fax Number: \_\_\_\_\_

Fax Number: \_\_\_\_\_

*Note: For more locations, please provide on a separate sheet of paper.*

Credentialing Contact Name: \_\_\_\_\_

Credentialing Contact Address: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Credentialing E-Mail Address: \_\_\_\_\_

Tax ID (W-9 must be submitted with request): \_\_\_\_\_

Provider Information (if Group request, include all Providers in the Group): provide extra sheet if necessary

<b>Provider/Provider Group Name:</b>	<b>Specialty:</b>	<b>Hospital Affiliation(s):</b>	<b>Provider NPI:</b>
_____	_____ PCP Y/N	_____	_____
_____	_____ PCP Y/N	_____	_____
_____	_____ PCP Y/N	_____	_____
_____	_____ PCP Y/N	_____	_____
_____	_____ PCP Y/N	_____	_____
_____	_____ PCP Y/N	_____	_____

Please let us know your Panel status if Providers are PCP's: Open/Closed

\*Physicians must have hospital admitting privileges at a BMCHP-contracted hospital or must provide explanation of arrangements in place for members to be admitted to a Plan participating hospital

Is this group part of an ACO? If Yes, which ACO? \_\_\_\_\_

Does the provider offer any special services?    **YES**     **NO**

If Yes, please list: \_\_\_\_\_

What language(s) does the provider(s) speak? \_\_\_\_\_

What languages are spoken by the office staff? \_\_\_\_\_

Population Served: (optional): \_\_\_\_\_

Why is the provider interested in contracting with BMC HealthNet Plan? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Does the interested provider offer any special services that should be taken into consideration when reviewing this request for an Agreement for participation? If yes, please share:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Has the provider received requests to care for any of our members? YES  NO

**Type of Agreement requested:**

Individual Contract: YES  NO  Group Contract: YES  NO

Facility Contract: YES  NO  Ancillary Contract: YES  NO

**Please return completed form and W-9 via  
e-mail to: [Provider.Info@bmchp-wellsense.org](mailto:Provider.Info@bmchp-wellsense.org)**

**DO NOT WRITE BELOW**

**Paperwork to be processed by Provider Engagement or Provider Processing Center**

<b>Date Request Received:</b>	<b>Processed by:</b>	<b>Added into Database:</b>	<b>Completed on:</b>