BOSTON MEDICAL CENTER
HEALTHNet PLAN

Letters of Interest Contract Request Form

Name of Interested Provider: _____

Main 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):

Provider Name:	Specialty:	Hospital Affiliations:	Provider NPI:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

*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

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

If Yes, please list: _____

What language(s) does the provider 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.ProcessingCenter@BMCHP-wellsense.org

DO NOT WRITE BELOW

Paperwork to be Processed by Provider Engagement or PPC

Date Request Received:	Processed by:	Added into Database:	Completed on: