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Phone: (800) 776-6959
Fax: (775) 356-5746



PROVIDER REQUEST FOR PARTICIPATION
Please complete and return this form via FAX or MAIL to the above address.

1. Provider Name(s): _____
Are you presently a Participating Provider with UHN? YES___ or NO ___
***If yes, please list current practice name** _____
***Will you be terminating with this practice? YES___ or NO ___ If yes, date of termination:** _____
Are you joining an existing Participating Provider/Group? YES___ or NO___
***If yes, Participating Physician/Group name:** _____ **Effective date:** _____
***Tax ID Number:** _____

2. Applying as: (check one category only)

Primary Care Physician (Board Certified or Board Eligible Family Practitioners, Internist, Pediatrician, MD's, DO's)
Please specify: _____

Specialist (Physicians other than PCP's who are Board Certified/Eligible in their designated clinical practice)
Please list specialty: _____

UHN Health Provider (Licensed, certified, registered, or otherwise authorized non-MD, DO providers of direct patient care services)
List scope of service: _____

ANCILLARY – Specify: _____

3. Group/Practice TIN: _____ Name if applicable: _____

4. List address(es) of each practice location (associated with the TIN listed above) and contact information:

- **Contact Name:** _____
Billing Address: _____
Telephone Number: _____ Fax Number: _____
- **Primary Office Address:** _____
Telephone Number: _____ Fax Number: _____
- **Second Office Address:** _____
Telephone Number: _____ Fax Number: _____
- **Authorized Credentialing Contact Name:** _____
Address _____
Telephone Number: _____ Fax Number: _____

5. Hospital Privileges:

6. Please attach a **Letter of Intent** listing any special consideration or services you provide. (optional)

"I certify the above information is correct to the best of my knowledge."

Authorized Signature

Date

*Neither Universal Health Network, nor its representatives, make any guarantee, express or implied, that receipt of this "Preliminary Request for Participation" signifies acceptance into the UHN Network of Providers. **Failure to complete all of the necessary information requested above will further delay the processing of this request.***