LETTER OF INTENT

YES, I/we do want to participate in the Plans listed below:

o	Prominence HealthFirst HMO	Northern Nevada *(only)*	
o	Prominence Preferred Health Care Network PPO (PHCN) and Prominence Health Choice PPO	Northern Nevada	Southern Nevada
▫	Universal Health Network (UHN)	Northern Nevada	Southern Nevada
▫	Nevada Preferred Professionals (NPP)	Northern Nevada	Southern Nevada

Date: _____

Practitioner/Provider Name *(Please Print)*: _____ NPI #: _____

Practitioner/Provider E-Mail: _____

Board Certified: Yes No If "Yes", What Specialty?: _____

Tax Identification Number: _____ Group NPI # (if applicable): _____

Name of Group (if applicable): _____

Physical Address: _____

Phone: ( ) _____ Fax: ( ) _____

Secondary Address: _____

Phone: ( ) _____ Fax: ( ) _____

Mailing Address (if different from above): _____

Phone: ( ) _____ Fax: ( ) _____

Remittance Address (if different from above): _____

Specialty: _____ Secondary Specialty: _____

Contact Name & Title: _____ Phone: _____

Contact E-Mail: _____

A completed W-9 (Tax Identification Form) MUST be attached.

PLEASE FAX THE COMPLETED FORM WITH W-9 TO:

Southern Nevada	***Northern Nevada***
Fax: 702.871.4737	***Fax: 775.770.9043***