



**COPY OF PROVIDER CONTRACT REQUEST FORM**

Practice or Physician's Name: \_\_\_\_\_

TIN: \_\_\_\_\_

Requested By: \_\_\_\_\_

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

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

Email: \_\_\_\_\_

Please list address for mailing: \_\_\_\_\_

\_\_\_\_\_

*The undersigned hereby certifies that he / she is authorized to request and / or receive a copy of the provider agreement.*

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

**PLEASE MAIL OR FAX THE COMPLETED FORM TO:**

**Nevada Preferred Healthcare Providers  
Attn: Provider Relations  
PO Box 30007  
Reno, Nevada 89520-3007  
Phone: 800.776.6959  
Fax: 775.352.2475**