



## PROVIDER REQUEST FOR PARTICIPATION

1. Provider Name(s): \_\_\_\_\_

Are you presently a Participating Provider with Nevada Preferred? 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: \_\_\_\_\_

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

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: \_\_\_\_\_

**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 / Authorized Credentialing Name:** \_\_\_\_\_

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

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

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

• **Primary Office Address:** \_\_\_\_\_

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

• **Second Office Address:** \_\_\_\_\_

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

5. Hospital Privileges:

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

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

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

\_\_\_\_\_  
Authorized Signature

\_\_\_\_\_  
Date

**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**

*Neither Nevada Preferred Healthcare Providers, nor its representatives, make any guarantee, expressed or implied, that receipt of this "Preliminary Request for Participation" signifies acceptance into the network of providers. Failure to complete all of the necessary information requested above will further delay the processing of this request.*