Prime Healthcare

# Prime Healthcare Network

## Contract Request Form

Thank you for your interest in joining Prime Healthcare Network.
Please complete the form below and return along with W9 for review.

***If you are joining an existing group in network, please complete the provider change request form to submit updates.***

**Type of Agreement:** ☐ **Individual** ☐ **Group/Facility**

Are you affiliated with a Prime Healthcare facility? ☐YES ☐NO

If yes, facility name_____

Are you contracted with BlueCross BlueShield? ☐YES ☐NO

**Provider Information:**

Name _____ Degree_____

Specialty_____ Type I NPI_____

Office Address_____

City_____ State_____ Zip_____

**Group Information:**

Group Name *as listed on W9* _____

Tax ID: _____ Type II NPI_____

Billing Address *as listed on W9*_____

Authorized Signer _____

**Primary Point of Contact:**

Name_____ Title_____

Phone_____ Fax_____

Email_____

*Please note, acceptance of a provider request form does not guarantee network participation.

**Please return this form via fax or email, along with a W-9 to:**
**Prime Healthcare Management**
**Attn: Contracts**
**Fax:** 909-235-4405
**Email:** EHPprovidercontracts@primehealthcare.com