PROVIDER INTEREST FORM

Please note, this form is for new providers only.

PROVIDER INFORMATION

First Name | Middle Initial | Last Name

Degree | Date | Facility Name/Name of Physician Group | Accreditations

Tax ID# | Group/Individual NPI | Taxonomy Code | Contact Person

Primary Office Address* | City | Zip | Primary County

Office Hours | Phone# | Fax #

E-Mail

* Any additional locations must be submitted on letterhead with address, phone, fax and office hours.

PROVIDER TYPE/DESCRIPTION (CHECK ONE)

☐ **Primary Care/Specialists:** Family Practice, Internal Medicine ☐ Group Practice ☐ Solo Practitioner

Specialty: _____

Board Certified: Yes ☐ No ☐ Board Eligible: Yes ☐ No ☐

Primary Hospital Affiliation | CAQH ID# (if applicable):

Other Hospital Affiliations

Group Name | Partners Names

List other physicians or any APRN's/PA's rendering services in your office(s):

Please make sure this form is completely filled out and legible. Submission of this form does not guarantee participation in the network, all decisions are based off on network need and Credentialing factors. Please submit the completed form to

Providerrelations@leonhealth.com