



## REQUEST FOR PARTICIPATION

Return to Health Choice Utah Network Services Department: Fax (801) 984-3480

Please complete entire form. (COMPLETE ONE SHEET PER LICENSED PROFESSIONAL)

REASON FOR APPLYING (Attach Nominations): \_\_\_\_\_

CONTACT NAME AND NUMBER: \_\_\_\_\_

PROVIDER NAME: \_\_\_\_\_

PROVIDER NPI: \_\_\_\_\_

PROVIDER SPECIALTY(IES): \_\_\_\_\_

PROVIDER BOARD CERTIFICATIONS: \_\_\_\_\_

PRACTICE NAME: \_\_\_\_\_

PRACTICE ADDRESSES (attach additional): \_\_\_\_\_

CITY, STATE, ZIP: \_\_\_\_\_

OFFICE PHONE: \_\_\_\_\_

OFFICE FAX: \_\_\_\_\_

OFFICE HOURS: \_\_\_\_\_

BUSINESS EMAIL: \_\_\_\_\_

ARE YOU REGISTERED WITH UTAH MEDICAID: Y  / N

DO YOU PARTICIPATE WITH MEDICARE: Y  / N

PROVIDER'S GENDER  M  F PROVIDER'S LANGUAGES: \_\_\_\_\_

GENDER(S) ACCEPTED  M  F PT AGE RANGE  0-99  0-16  0-18  18-99  21-99  OTHER: \_\_\_\_\_

STAFF LANGUAGES: \_\_\_\_\_ # MEMBERS WHO CAN BE ACCOMMODATED BY PRACTICE \_\_\_\_\_

HOSPITAL PRIVILEGES, PRIVILEGE STATUS, AND % OF ADMISSIONS TO EACH HOSPITAL:  
\_\_\_\_\_

COVERING PHYSICIANS: \_\_\_\_\_

TOTAL NUMBER OF PHYSICIANS AND OTHER LICENSED PROFESSIONALS (FOR GROUPS): \_\_\_\_\_

Health Choice Internal Use Only (DGHNA):