TRICARE West (T2017)

Join Our Network!

Identifying Information

Practice Legal Name (as shown on W9) **Required**	**Tax Identification Number/Employer Identification Number Required**	**Organizational NPI**

Is this a multi-specialty practice? ☐ YES ☐ NO

Facility? ☐ YES ☐ NO

Hospital? ☐ YES ☐ NO

Inpatient Rehab Center? ☐ YES ☐ NO

Do you provide primary care services? ☐ YES ☐ NO

Medicare Designation:
☐ FQHC (Federally Qualified Health Center)
☐ RTC (Rural Health Clinic)

If yes to multi-specialty or facility, select one or more of the specialty services provided by this organization.

☐ Audiology	☐ Home Health Agency	☐ Outpatient Physical Therapy
☐ Cardiovascular Disease	☐ Laboratory	☐ Pulmonary Disease
☐ DME	☐ Neurology	☐ Surgery, Colon/Rectal
☐ Dermatology	☐ OB-GYN	☐ Surgery, Neurological
☐ Gastroenterology	☐ Ophthalmology	☐ Surgery, Orthopedic
☐ Hematology	☐ Otolaryngology	☐ Thoracic/Cardio Surgery
☐ Urology	☐ Ambulatory Surgery Center	☐ Surgery, Other
☐ Other:		

Professional Liability Insurance

Effective Date (mm/dd/yyyy)	**Expiration Date** (mm/dd/yyyy)	**Amounts of Coverage**
______________	______________	$ ______________

Medicare Participation Information (All fields in the section are required)

Medicare Certification Number	**Original Certification Date**	**Current Certification Date** (mm/dd/yyyy TO mm/dd/yyyy)
	(mm/dd/yyyy) ______________	______________

Contracting Point of Contact Information (All fields in the section are required)

First Name	**Last Name**	**Phone Number**	**Fax Number**	**Email Address**

Street Address	**City**	**State**	**ZIP Code**

Practice Locations

Location 1

Practice Street Address	**City**	**State**	**ZIP Code**
Pay to Address	**City**	**State**	**ZIP Code**

Location 2

Practice Street Address	**City**	**State**	**ZIP Code**

Submit this completed form along with a copy of your W-9 to HNFS:

Email: HNFST2017ProvRel@healthnet.com

Fax: (757) 766-6192

Mail: Health Net Federal Services, LLC
514 Butler Farm Road
Hampton, VA 23666

Note: If you are a behavioral health provider, do not fill out this form. Please go to www.mhn.com/provider/start.do to join the network.

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