FACILITY / ANCILLARY NETWORK INTEREST PROFILE FORM

General Information

Contact Person: | Email: | Date: / /

Phone #: | Fax #: | Tax ID #:

Operating Name *(DBA)*: | License #:

Medicare # (Required for participation): | NPI #:

Medicaid #:

Provider Physical Location:

Multiple Locations? ☐ Yes ☐ No ***If yes, please attach additional location information**

Provider Specifications

Please check all applicable services for your provider type

Facility

- ☐ Acute Hospital
  - ☐ Cardiac Surgery
  - ☐ Cardiac Caths
  - ☐ Infusion/Chemotherapy
- ☐ Ambulatory Surgery Center
- ☐ Diagnostic Radiology
  - ☐ Mammography
- ☐ Ambulance/Transport Service
- ☐ Behavioral Health (Outpatient)
- ☐ Behavioral Health (Inpatient)
- ☐ Dialysis
- ☐ SNF
- ☐ Urgent Care

Ancillary

- ☐ Home Health Nursing
  - ☐ Home PT/OT/ST which?________________
  - ☐ Home Infusion
  - ☐ Wound Care
  - ☐ Psych Nursing
- ☐ DME
  - ☐ Orthotics/Prosthetics
  - ☐ Respiratory Therapy
- ☐ Sleep Studies- Home ☐ Facility ☐

Are you accredited? ☐ Yes ☐ No ***If yes, list the accrediting entity:**
(Required for DME and Free Standing Radiology providers, please attach proof of accreditation)

Do you carry general and professional liability insurance? If so, how much? ***General:*** ***Liability:***

Service Areas Covered:

☐ Houston- Southeast TX ☐ San Antonio (Bravo Health Only) ☐ Valley (HealthSpring Only)

☐ Dallas/Ft Worth- North TX ☐ El Paso (Bravo Health Only) **(*Please attach a listing of counties covered)**

Are you interested in servicing multiple states? ☐ Yes ☐ No ***If yes, please attach information on servicing states**

How did you hear about HealthSpring/Bravo Health?

HealthSpring/Bravo Health Use Only

Committee Review Date: | Approved/Denied:

Your request will be presented at HealthSpring/Bravo Health Network Review Committee meeting; you will be notified once a decision is rendered within30 days. Determinations are based on network need and current availability of services. PLEASE NOTE: Requesting, obtaining, or submitting a profile form does not guarantee or imply that you will be accepted to participate in the HealthSpring/Bravo network, nor does it entitle you to payment of any services rendered to a HealthSpring/Bravo Health member prior to receiving written confirmation of an effective date and meeting any and all applicable authorization requirements. All providers are subject to HealthSpring/Bravo Credentialing requirements and applicable state and federal guidelines as set forth in the HealthSpring/Bravo Health participating provider agreement.

This form can be downloaded, printed and sent by fax to the number below. You may also complete it electronically and return via email. **If this form is returned without all required questions answered, the form will not be processed**.

Email: LetterofInterest@HealthSpring.com **Fax:** 832-553-3418 **Phone:** (Local) 832-553-3300 (Toll Free) 1-888-501-1115