Network Participation Request - Physician

PARAMOUNT
HMO/PPO, MEDICARE, MARKETPLACE

Please complete the information below and save the document. Attach it to an email, along with a W9, completed provider roster and submit to Provider Contracting at PHCProvider.Contracting@MedMutual.com. **Incomplete forms will be returned and not considered for participation.**

Provider Name *(Include dba name if applicable)*	
Provider Billing NPI	
Legal contracting name as it should appear on contract *Must be supported by attached W9*	
Medicare Number (PTAN) *Required for participation in Medicare Advantage*	
Tax identification number to be covered under this contract *Must be supported by attached W9*	
Billing Type:	Professional (1500 Form) ☐ Facility (UB92 Form) ☐
Product(s) *(mark all that apply)*	Medicare Advantage ☐ Commercial ☐ Marketplace/Exchange ☐
Hospital Privilege Affiliations *Affiliation with a participating provider is required for Commercial and Marketplace/Exchange*	
Primary Care Physician?	Yes ☐ No ☐
Specialty:	
Hospital Based Provider	Yes ☐ No ☐ *(if yes, list facility)*
Telehealth services provided?	Yes ☐ No ☐
Primary location to be covered under this contract	Address:
	County:
	Phone:
	Email:
Contract Contact *(Person to receive contract)*	Name:
	Phone:
	Email:
Credentialing Contact	Name:
	Phone:
	Email:
Contract Mailing Address	Street Address: City, State, Zip:

Please email back to PHCProvider.Contracting@MedMutual.com