EST. 1993

Healthcare Networks of America

Provider Credentialing Form

Provider: _____

Address: _____

Phone Number: _____ Fax Number: _____

Website: _____

Credentialing Contact: _____

Credentialing Contact Email: _____

Doctor/Provider Email: _____

Federal Tax ID Number: _____

National Provider Identifier (NPI) Number: _____

Malpractice Carrier: _____ Exp.: _____

State License Number: _____ Exp.: _____

DEA Certificate Number: _____ Exp.: _____

Annual Credentialing Fee: **$145**

Check #: _____ Master Card/Visa ( ) American Express ( )

Card Number: _____

Exp. Date: _____ 3 or 4 digit security code:_____

I authorize the above card to be charged for my credentialing fee.

To obtain a copy of our fee schedule/health plan list please e-mail us at providerrelations@hna-net.com

You consent to us contacting you using all channels of communication and for all purposes. We will use the contact information you provide to us. This may include text messages, automatic telephone dialing systems, prerecorded voice and/or fax. We do not sell or distribute our lists. This information is used for internal purposes only.

Signature _____ Date _____

P.O. BOX 71717 PHOENIX, ARIZONA 85050

PHONE 877-311-3338 FAX 602.485.3100

WWW.HNA-NET.COM