

## **HOSPITAL/FACILITY BASED PROVIDER APPLICATION for Participation in Encore Health Network**

- COMPLETE THE ATTACHED OFFICE AND BILLING INFORMATION FORM.
- ATTACH A LIST OF ALL PROVIDERS THAT BILL UNDER THIS GROUP. BE SURE TO INCLUDE SPECIALTY AND BOARD CERTIFICATION STATUS
- PLEASE KEEP US INFORMED WHENEVER YOU ADD OR TERM PROVIDERS FROM THIS GROUP.
- ENCORE DOES NOT CREDENTIAL FACILITY BASED PROVIDERS SPECIALIZING IN ANESTHESIOLOGY, EMERGENCY MEDICINE, PATHOLOGY AND RADIOLOGY, HOWEVER, ALL WILL BE LOADED INDIVIDUALLY INTO ENCORE SYSTEMS FOR DOWNLOAD INTO DIRECTORIES.

THANK YOU.  
Encore Health Network Provider Relations Staff  
888-574-8180

**ENCORE HEALTH NETWORK  
HOSPITAL/FACILITY BASED PROVIDER INFORMATION**

**I. PRIMARY OFFICE PRACTICE INFORMATION**

Provider Name: \_\_\_\_\_  
Primary Office/Corporate Name: \_\_\_\_\_  
TIN: \_\_\_\_\_ Specialty: \_\_\_\_\_ Brd Certified  Yes  No  
DOB: \_\_\_\_\_ SSN: \_\_\_\_\_ NPI: \_\_\_\_\_  
Primary Office Manager: \_\_\_\_\_ County: \_\_\_\_\_  
  
Primary Office Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Primary Telephone: (\_\_\_\_) \_\_\_\_\_ Primary Fax: (\_\_\_\_) \_\_\_\_\_

**II. PRIMARY OFFICE BILLING INFORMATION**

Is the Primary Billing Address the same as the Primary Office Address?  Yes  No  
  
Primary Billing Name: \_\_\_\_\_  
Primary Contact Name: \_\_\_\_\_  
Primary Billing Address: \_\_\_\_\_  
City \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Primary Billing Telephone: (\_\_\_\_) \_\_\_\_\_ Primary Billing Fax: (\_\_\_\_) \_\_\_\_\_

**III. SECONDARY OFFICE PRACTICE INFORMATION**

Not Applicable  
Secondary Office/Corporate Name: \_\_\_\_\_  
Secondary Office Manager: \_\_\_\_\_  
Secondary Office Address: \_\_\_\_\_  
City \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Secondary Telephone: (\_\_\_\_) \_\_\_\_\_ Secondary Fax: (\_\_\_\_) \_\_\_\_\_  
  
TIN: \_\_\_\_\_

**IV. SECONDARY OFFICE BILLING INFORMATION**

Not Applicable  Secondary Billing information same as Primary Billing Information  
  
Secondary Billing Name: \_\_\_\_\_  
Secondary Contact Name: \_\_\_\_\_  
Secondary Billing Address: \_\_\_\_\_  
City \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Secondary Billing Telephone: (\_\_\_\_) \_\_\_\_\_ Secondary Billing Fax: (\_\_\_\_) \_\_\_\_\_