MHNet

CREDENTIALING REQUEST FORM

Thank you for your interest in becoming a network provider for MHNet. Please answer each question completely and thoroughly. Write N/A if Not Applicable. Any question left blank may delay the processing of your credentialing

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Date: _____ **Provider NPI Number**: _____

Provider Name: _____ **Licensure**: _____

Gender: F **Date of Birth:** _____ **Email Address:** _____

Degree Type: _____ **License Number:** _____ **State of License:** _____

Provider Tax ID: _____ **CAQH ID#:** _____

SERVICE LOCATION INFORMATION:

Service Locations Address: _____ **Ste:** _____

City: _____ **County:** _____ **State:** _____ **Zip code:**_____

Phone: _____ **Fax:** _____

Group Name: _____

ADDITIONAL SERVICE LOCATION INFORMATION (if applicable)

Service Locations Address: _____ **Ste:** _____

City: _____ **County:** _____ **State:** _____ **Zip code:**_____

Phone: _____ **Fax:** _____

Group Name: _____

If you have additional locations, please add on another sheet

MAILING ADDRESS:

The Mailing Address is the same as the Primary Service location: ☐

Mailing Address: _____ **Ste:** _____

City: _____ **County:** _____ **State:** _____ **Zip code:**_____

Phone: _____ **Fax:** _____