

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

Date:	Provider NPI Number:			
Provider Name:	Licensure:			
Gender:	Date of Birth:	Email Address	s:	_
Degree Type:	License Number:	State	of License:	
Provider Tax ID:	CAQH I	D#:		
SERVICE LOCATION IN	NFORMATION:			
Service Locations Addres	s:	Ste:		
City:	County:	State:	Zip code:	
Phone:	Fax:			
Group Name:				
ADDITIONAL SERVICE	LOCATION INFORMATION (if applicable)		
Service Locations Addres	s:	Ste:		
City:	County:	State:	Zip code:	
Phone:	Fax:			
Group Name:				
If you have additional loc	cations, please add on another sh	eet		
MAILING ADDRESS:				
The Mailing Address is th	ne same as the Primary Service l	ocation:		
Mailing Address:		Ste:		
City:	County:	State:	Zip code:	
Phone:	Fax:			