ILLINOIS HEALTH PRACTICE ALLIANCE

To contract with Illinois Health Practice Alliance, please complete the following form and fax to: (866) 912-6286 or email IHPAContracting@envolvehealth.com. Upon receipt of completed form, the Contracting Department will draft a contract and make available to you via e-mail for your review and signature along with additional instructions. You may add additional pages to provide all other places of service. IHPA looks forward to working with you!

Request for Network Participation Form

Date of Request:	Requested by:	Title:
Requestor's Phone No:	Email:	

MAIN PROVIDER INFORMATION

Provider Name:	Group Name:
Tax ID:	Group NPI:
Specialty:	Taxonomy:
Individual NPI:	Medicaid No:

Physical Address (POS): Primary Place of Service, (POS)	**Billing Address: (Must be a Physical Address) (Different from Billing Co.)**
City: State: Zip:	City: State: Zip:
Phone:	Phone:
Fax:	Fax:
Mailing Address:	**Pay To Address:**
City: State: Zip:	City: State: _____Zip:
Phone:	Phone:
Fax:	Fax:

FOR OFFICE USE ONLY

Check List Completion Date:___/____/____

- ❑ Signed Provider Participation Agreement
- ❑ Signed Owner & Disclosure Form
- ❑ W-9 Form
- ❑ Provider Roster/New Provider Address Forms
- ❑ Illinois License and Liability Insurance
- ❑ EFT

IHPA Decision Status: _____

Decision Date: ___/____/_____

Type Provider Contract:

❑ CMHC ❑ SUPR ❑ OTHER: _____

VBC Level Options:

❑ **ProviderCo** ❑ **Contracted Provider**

Last Updated 10/2020