



Please fill out all fields.

**\*Forms with missing information will not be accepted\***

For questions contact WH\_Contracting@hcupnv.com

## Letter of Interest

### General Information

Practice Name (DBA) \_\_\_\_\_

Legal Entity Name \_\_\_\_\_  
(if different from above)

Specialty \_\_\_\_\_

Tax ID # \_\_\_\_\_ Group NPI \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

Credentialer \_\_\_\_\_

Email \_\_\_\_\_

### PROVIDER(S):

Number of Providers \_\_\_\_\_ Attach Roster if Needed

Provider Name(s) - First Name, Last Name, Credentials

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### LOCATION(S):

Location Address(es) - List all practice locations including billing location Attach Additional Pages if Needed

Address \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### Payor Group Requested (Check All That Apply)

Cigna LocalPlus

Teachers Health Trust