Please fill out all fields.

Forms with missing information will not be accepted

For questions contact networkrelations@wellhealthqc.com

Letter of Interest

General Information

Practice Name (DBA) _____

Legal Entity Name (if different from above) _____

Specialty _____

Tax ID # _____

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 ☐ SilverSummit ☐ Teachers Health Trust