Letter of Interest – Individual or Group

Business Name (on your W-9 Form):____

Practice Name (doing business as/dba):____

Federal Tax ID#:_______________________________(**Please attach a copy of your W-9 form**)

1. If you are a sole proprietor, what is your Individual NPI#:_____________________________
2. If you are a Group Practice, what is your Organizational NPI#:_________________________
3. Practice Specialty:____
4. If you are a Behavioral Health Provider, what is your licensure? ______________________
5. Addresses (please attach list if more than one office location):
   Physical:____
   Billing:____
   Mailing:____
6. Scheduling Phone:_______________________ Referral Fax:___________________________
7. Billing Phone:___________________________ Fax:_____________________________
   Billing Contact Person & Title: ____
   Billing Contact E-Mail:____
8. Primary Practice Contact Person & Title:____
9. Primary Practice E-Mail:____
10. Electronic Claims Filing Capability?* Yes ___ No ___
    *Network providers are required by contract to submit electronic claims to NMHC.
11. Please indicate the E-mail address for delivery of your **final executed contract**:
    Executed contract E-mail:____

Please return form via fax to 1-888-282-3483 or via email to provider.services@mynmhc.org.