INTEGRIS HEALTH Partners

Participation Request Form

- Please complete the form in its entirety. This form will be used to determine your eligibility to join INTEGRIS Health Partners (IHP).
- If you have or will be applying for privileges at an INTEGRIS Health facility, you will not need to complete the IHP Credentialing application. Please visit https://integrisok.com/ihp/prospective-providers for additional forms to complete this process.
- Please return this form & a W9 to INTEGRIS Credentialing Office at IHPCredentialing@integrishealth.org. You will receive an e-mail with further instructions.

Please see attached documents required for the full initial application.

Last Name	First Name
Birth Date	Primary Degree (APRN, MD, etc.)
NPI Number	
Provider E-mail (must be unique to this provider)	

If you have an admin completing this application, please complete the Credentialing Contact section below.

Credentialing Contact Name	Credentialing Contact Phone Number
Credentialing Contact E-Mail (cannot be the same as the provider)	

Primary Office Location	
Practice Name (as listed on the W9)	**City and State of Practice**

For Advance Practice Providers:				
Is your supervising physician in network with INTEGRIS Health Partners?	**Yes**		**No**	
Please list your supervising physician(s):				

Specialty Information				
Are you board certified?	**Yes**		**No**	
If not certified, are you board eligible?	**Yes**		**No**	
If not board certified or eligible, please explain your board status or lack of certification.				
Education Specialty				
Primary Specialty				

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Admitting Privileges				
Do you possess admitting privileges at an in-network facility?	**Yes**		**No**	
Do you have admitting privileges outside of the IHP Network?	**Yes**		**No**	
Please list ALL facilities in which you hold privileges.				

To see a list of IHP in-network facilities, visit http://www.hchlogix.com/ProviderSearch or request a copy of the list from our office.

Medicare Opt-Out				
Are you currently opted-out of Medicare through CMS.gov?	**Yes**		**No**	
DEA/OBNDD				
Do you possess and plan to maintain a DEA and OBNDD?	**Yes**		**No**	

Healthcare Highways						
Are you contracted with Healthcare Highways?	**In Process**		**Yes**		**No**	

If you are not contracted with HCH, please the following link: https://www.healthcarehighways.com/request-a-contract?hsLang=en.
If you are contracted with Healthcare Highways, please visit Providers: Tailored Plans for Patient-Centric Care | Healthcare Highways to ensure your inofmation is updated.

Reason for request
What is the reason you would like to join INTEGRIS Health Partners?

I expressly agree that, in consideration for the Network's willingness to review and consider the information provided herein, I waive and release any claims, including but not limited to any claim of entitlement to a hearing or appellate review, against the Network, its participants, officers, directors and agents, arising from a decision to not provide me an application for membership in the Network. I expressly agree that such a decision is an administrative and business decision which may be made by the Network independent of any professional review and that such a decision will not result in any report to the National Practitioner Data Bank or any other agency. I also agree that if I am offered an application, granted participation, and fail to fulfill the conditions to which I have agreed, my network eligibility may be administratively terminated without giving rise to any claim of any nature against INTEGRIS Health Partners, its participants, officers, directors, and agents. I hereby attest that the information provided above is true and correct. I fully understand that any significant misstatements in or omissions from this document constitute cause for denial of my request for an application, denial of appointment to the network, or termination from the network. I will immediately notify INTEGRIS Health Partners if any information provided in this document changes or is no longer true and correct.

Provider Name: _____

Signature: _____ Date: _____