Network Provider Information Form (PIF)

Note: If you are not currently contracted with Hennepin Health or have not received an offer to contract with Hennepin Health, complete the Non-Network Provider Information Form found on our website at www.hennepinhealth.org.

Submit completed forms and any questions via email to hhnetworkmanagement@hennepin.us. **Remember to also include your W-9.** Please allow 15 business days for this information to be processed.

BUSINESS INFORMATION	
Legal Business Name *(as appears on W-9)*	
DBA Name	**Website Address**
Federal Tax ID	**NPI/UMPI**

ELECTRONIC CLEARINGHOUSE INFORMATION

Hennepin Health accepts electronic claims submission and sends remittance advices through:

- Change Healthcare (formerly Emdeon): www.changehealthcare.com (877-271-0054)
- RelayHealth: www.relayhealth.com (888-743-8735)
- ClaimLynx: www.claimLynx.com (952-593-LYNX (5969))

If you are not already registered with these clearinghouses, please contact them via the telephone or website address provided.

Please complete the following regarding your claims submissions and remittance advices:

Electronic Claims Submission Type ☐ 837I ☐ 837P

☐ Change Healthcare (formerly Emdeon) ☐ ClaimLynx
☐ RelayHealth ☐ Other

Remittance Advice (835)

☐ Change Healthcare (formerly Emdeon) ☐ ClaimLynx
☐ RelayHealth ☐ Other

LOCATION INFORMATION

Address	City	State	Zip Code

Primary Phone	Appointment Phone

After Hours Phone	Fax	TDD

Please specify your days/hours of operation *(e.g., M-F 8 a.m. - 5 p.m., Sat 8 a.m. - 1 p.m., Sun closed)*

Publish location in directory? ☐ Yes ☐ No **Accepting new patients?** ☐ Yes ☐ No

Please list all hospital affiliations for this location

Please specify all languages spoken at this location

Service accessibility information:

1. Do you offer flexible appointment hours at this location? ☐ Yes ☐ No
2. Is this location wheelchair accessible? ☐ Yes ☐ No
3. Is transfer assistance available? ☐ Yes ☐ No
4. Are private waiting areas available? ☐ Yes ☐ No
5. What is the approximate distance from this location to public transportation?
    a. 1 to 2 blocks ☐
    b. 3 to 5 blocks (1/4 mile) ☐
    c. 6 to 8 blocks (1/2 mile) ☐
    d. 9 to 10 blocks (3/4 mile) ☐
    e. 11-13 blocks (1 mile) ☐
    f. More than 2 miles to public transportation ☐
6. Is there parking lot or ramp access for this location? ☐ Yes ☐ No

Please check the box if you have additional locations ☐
Visit www.hennepinhealth.org to access the provider location roster.

SERVICES AT THIS LOCATION *(check all that apply)*			
☐	ACUPUNCTURE	**CHEMICAL HEALTH** (options below)	
☐	AUDIOLOGY	☐	ASSESSMENT/DIAGNOSIS (RULE 25)
☐	CHILD AND TEEN CHECKUPS	☐	IP HOSPITAL TREATMENT
☐	CLINIC SVCS	☐	OP METHADONE TREATMENT
☐	CULTURALLY SPECIFIC SVCS (PLEASE SPECIFY)	☐	OP TREATMENT
☐	DIABETIES MANAGEMENT	☐	RESIDENTIAL NON-HOSPITAL TREATMENT
☐	DIAGNOSTICS	☐	OTHER (PLEASE SPECIFY)
☐	DOULA SVCS	**MENTAL HEALTH** (options below)	
☐	EATING DISORDERS	☐	ADULT REHABILITATIVE MENTAL HEALTH SERVICES (ARMS)
☐	EYE EXAMS	☐	ASSERTIVE COMMUNITY TREATMENT (ACT)
☐	EYE WEAR – ONSITE	☐	BEHAVIORAL HEALTH HOME (BHH)
☐	GENDER HEALTH SVCS	☐	CERTIFIED PEER SPECIALIST
☐	HEALTH CARE HOME	☐	CHILDREN'S MENTAL HEALTH
☐	HOSPICE	☐	DAY TREATMENT
☐	LGBTQ	☐	DIALECTICAL BEHAVIORAL THERAPY
☐	DME (PLEASE SPECIFY)	☐	EARLY INTENSIVE DEVELOPMENTAL AND BEHAVIORAL INTERVENTION (EIDBI)
☐	OCCUPATIONAL THERAPY	☐	IP TREATMENT
☐	PAIN MANAGEMENT	☐	INTENSIVE REHABILITATIVE MENTAL HEALTH SERVICES (IRTS)
☐	PHYSICAL THERAPY	☐	OP TREATMENT
☐	PRIMARY CARE CLINIC SVCS	☐	TARGETED CASE MANAGEMENT
☐	RESPIRATORY THERAPY	☐	OTHER (SPECIFY TYPE)
☐	SMOKING CESSATION	**TRANSPORTATION** (options below)	
☐	TELEMEDICINE	☐	EMERGENCY MEDICAL
☐	URGENT CARE	☐	PROTECTED TRANSPORTATION
☐	OTHER (PLEASE SPECIFY)	☐	SPECIALIZED MEDICAL TRANSPORTATION
		☐	CURB TO CURB SERVICE
		☐	DOOR THROUGH DOOR SERVICE
		☐	DOOR TO DOOR SERVICE
		☐	OTHER (PLEASE SPECIFY)

CONTACT INFORMATION			
Contracting and Correspondence Mailing Street Address ☐ *Same as location address*	**City**	**State**	**Zip Code**
Contracting Contact *(name, email, phone)*			
Credentialing Contact *(name, email, phone)*			
Billing Contact *(name, email, phone)*			

Date of Form Completion

Please note that once your completed form and W-9 is received, additional information may be requested. Thank you!