



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 30 business days for this information to be processed.

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

ELECTRONIC CLEARINGHOUSE INFORMATION
<p>Hennepin Health accepts electronic claims submission and sends remittance advices through:</p> <ul style="list-style-type: none"> • 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)) <p>If you are not already registered with these clearinghouses, please contact them via the telephone or website address provided.</p> <p>Please complete the following regarding your claims submissions and remittance advices:</p> <p>Electronic Claims Submission Type <input type="checkbox"/> 837I <input type="checkbox"/> 837P</p> <p><input type="checkbox"/> Change Healthcare (formerly Emdeon) <input type="checkbox"/> ClaimLynx <input type="checkbox"/> RelayHealth <input type="checkbox"/> Other</p> <p>Remittance Advice (835)</p> <p><input type="checkbox"/> Change Healthcare (formerly Emdeon) <input type="checkbox"/> ClaimLynx <input type="checkbox"/> RelayHealth <input type="checkbox"/> Other</p>

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? <input type="checkbox"/> Yes <input type="checkbox"/> No Accepting new patients? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Please list all hospital affiliations for this location			
Please specify all languages spoken at this location			
Service accessibility information: <ol style="list-style-type: none"> 1. Do you offer flexible appointment hours at this location? <input type="checkbox"/> Yes <input type="checkbox"/> No 2. Is this location wheelchair accessible? <input type="checkbox"/> Yes <input type="checkbox"/> No 3. Is transfer assistance available? <input type="checkbox"/> Yes <input type="checkbox"/> No 4. Are private waiting areas available? <input type="checkbox"/> Yes <input type="checkbox"/> No 5. What is the approximate distance from this location to public transportation? <ol style="list-style-type: none"> a. 1 to 2 blocks <input type="checkbox"/> b. 3 to 5 blocks (1/4 mile) <input type="checkbox"/> c. 6 to 8 blocks (1/2 mile) <input type="checkbox"/> d. 9 to 10 blocks (3/4 mile) <input type="checkbox"/> e. 11-13 blocks (1 mile) <input type="checkbox"/> f. More than 2 miles to public transportation <input type="checkbox"/> 6. Is there parking lot or ramp access for this location? <input type="checkbox"/> Yes <input type="checkbox"/> No 			
Please check the box if you have additional locations <input type="checkbox"/> Visit www.hennepinhealth.org to access the provider location roster.			

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

CONTACT INFORMATION

**Contracting and Correspondence Mailing
Street Address**

City

State

Zip Code

Same as location address

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!