



Provider Information Form for Non-Contracted Providers

Note: If you are currently contracted with Hennepin Health or have received an offer to contract with Hennepin Health, complete the Network Provider Information Form (PIF) 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 </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 |
| Primary Phone | | Fax | |

PRACTITIONER INFORMATION

Providers must be registered with the Minnesota Department of Human Services (DHS). Claims from providers not registered with DHS will be denied.

In the space below, please provide the rendering practitioner information for providers who are seeing Hennepin Health members.

| | | | |
|-------------------------|-------------------|------------------------|--------------|
| Last Name | First Name | Middle Initial | Title |
| DOB (MM/DD/YYYY) | NPI | SSN | |
| Specialty | | State License # | |

Additional rendering practitioner (if applicable)

| | | | |
|--|-------------------|------------------------|--------------|
| Last Name | First Name | Middle Initial | Title |
| DOB (MM/DD/YYYY) | NPI | SSN | |
| Specialty | | State License # | |
| Billing Contact <i>(name, email, phone)</i> | | | |

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|--------------------------------|
| Date of Form Completion |
|--------------------------------|