



## Contract Request Form

**Note:** Completion of this form does not guarantee that you will be awarded a contract. You will receive notification of our decision within 30 calendar days.

Submit completed forms and any questions via email to [hhnetworkmanagement@hennepin.us](mailto:hhnetworkmanagement@hennepin.us).

**Please select the product(s) for which you are requesting a contract:**

Hennepin Health-SNBC    Hennepin Health-PMAP and Hennepin Health-MNCare

**Legal Business Name** *(as appears on W-9)*

**DBA Name**

**NPI/UMPI**

**Website Address**

**Address**

**City**

**State**

**Zip Code**

**Is your organization designated as an Essential Community Provider (ECP)?**

No    Yes

**Please list your provider type, specialty and available services:**

**Do you have additional locations?**

No    Yes *(In the space below, list the location name(s) and city they are located in.)*

**Languages spoken at your location(s):**

**Contracting Contact** *(name, email, phone)*

**Date of Form Completion**