**Please Complete & Mail the following to Request Membership to the BHP Provider Network**

|  |
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| **Membership Request Application** |
| ***PERSONAL INFORMATION:*** |
| **Provider Name:**       **Degree:**  **Home Phone:**       **Cell Phone:**  **Email Address:**  **Provider Specialty(s):**  **Number of Years in Practice:**  **Electronic Medical Record :**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| ***CLINICAL PRACTICE INFORMATION:*** |
| **Primary Practice Location:**  **Primary Practice Address:**  (street address, city, state, zip code)  **Phone:**       **Fax:**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **(2) Practice Location:**  **Practice Address:**  (street address, city, state, zip code)  **Phone:**       **Fax:**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **(3) Practice Location:**  **Practice Address:**  (street address, city, state, zip code)  **Phone:**       **Fax:** |
| ***HOSPITAL/MEDICAL CENTER AFFILIATIONS:*** |
| **Institution:**  **Address:**  (street address, city, state, zip code)  **Phone:**       **Fax:**  **Services Provided:**  **Status:** ActiveCourtesyConsultingInactiveHonorary  **Appointment Date:**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Institution:**  **Address:**  (street address, city, state, zip code)  **Phone:**       **Fax:**  **Services Provided:**  **Status:** ActiveCourtesyConsultingInactiveHonorary  **Appointment Date:** |
| ***HOSPITAL/MEDICAL CENTER AFFILIATIONS (cont.):*** |
| **Institution:**  **Address:**  (street address, city, state, zip code)  **Phone:**       **Fax:**  **Services Provided:**  **Status:** ActiveCourtesyConsultingInactiveHonorary  **Appointment Date:**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Institution:**  **Address:**  (street address, city, state, zip code)  **Phone:**       **Fax:**  **Services Provided:**  **Status:** ActiveCourtesyConsultingInactiveHonorary  **Appointment Date:**  *\*\* If additional affiliations, please indicate on a separate piece of paper.* |
| ***REFERENCES:*** |
| **(1) Name of Reference:** **Title:**  **Email Address:**  **Phone:** **Fax:**  **Address, City/State/Zip:**  **(2) Name of Reference:** **Title:**  **Email Address:**  **Phone:** **Fax:**  **Address, City/State/Zip:**  **(3) Name of Reference:** **Title:**  **Email Address:**  **Phone:** **Fax:**  **Address, City/State/Zip:** |
| ***WHY DO YOU WANT TO JOIN BELLIN HEALTH PARTNERS?:*** |
| **Signature:**  **Date:** |
| **FOR OFFICE USE ONLY** |
| **Membership Request Received:**  **Date Taken to Board:** **Approved for Membership:** **YES**  **NO** |