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 90 calendar days. Please submit a W-9 with this form.

Submit completed forms and any questions via email to 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**	**Federal Tax ID**	
Address	**City**	**State**	**Zip Code**
Website Address:			
Is your organization designated as an Essential Community Provider (ECP)? ☐ No ☐ Yes			
Is your organization actively enrolled as a Minnesota Health Care Programs (MHCP) provider? ☐ 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**