



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
	Business license number

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. Does the organization provide cultural competency training? <input type="checkbox"/> Yes <input type="checkbox"/> No 2. Do you offer flexible appointment hours at this location? <input type="checkbox"/> Yes <input type="checkbox"/> No 3. Is this location wheelchair accessible? <input type="checkbox"/> Yes <input type="checkbox"/> No 4. Is transfer assistance available? <input type="checkbox"/> Yes <input type="checkbox"/> No 5. Are private waiting areas available? <input type="checkbox"/> Yes <input type="checkbox"/> No 6. 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"/> 7. Is the exam room large enough for patient and additional person; including space for assistive equipment? <input type="checkbox"/> Yes <input type="checkbox"/> No 8. Is the exam room equipped with a chair scale available to persons with disabilities? <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 *(check all that apply)*

<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
	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 (ARMHS)
<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 form completed

Please note that once your completed form and W-9 is received, additional information may be requested. Thank you!