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 *(as appears on W-9)*	
DBA Name	**Website Address**
Federal Tax ID	**NPI/UMPI** **Business License Number**

ELECTRONIC CLEARINGHOUSE INFORMATION

Hennepin Health accepts electronic claims submission and sends remittance advices through multiple Clearinghouses. If you are not already registered with a clearinghouse, please contact one of our participating partners found in the Clearinghouses section of our website.

Please complete the following regarding your claims submissions and remittance advices:

Electronic Claims Submission Type ☐ **837I** ☐ **837P**		**Remittance Advice (835)**	
Availity	☐	Availity	☐
Change Healthcare (formerly Emdeon)	☐	Change Healthcare (formerly Emdeon)	☐
Change Healthcare (formerly RelayHealth)	☐	Change Healthcare (formerly RelayHealth)	☐
HealthEC MN E-Connect (formerly IGI)	☐	HealthEC MN E-Connect (formerly IGI)	☐
Smart Data Solutions (formerly ClaimLynx)	☐	Smart Data Solutions (formerly ClaimLynx)	☐
Other:	☐	Other:	☐

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? ☐ Yes ☐ No **Accepting new patients?** ☐ Yes ☐ No		
Please list all hospital affiliations for this location		
Please specify all languages spoken at this location		

Service accessibility information:

1. Does the organization provide Cultural Competency training? ☐ Yes ☐ No
2. Do you offer flexible appointment hours at this location? ☐ Yes ☐ No
3. Is this location wheelchair accessible? ☐ Yes ☐ No
4. Is transfer assistance available? ☐ Yes ☐ No
5. Are private waiting areas available? ☐ Yes ☐ No
6. What is the approximate distance from this location to public transportation?
    a. 1 to 2 blocks ☐
    b. 3 to 5 blocks (1/4 mile) ☐
    c. 6 to 8 blocks (1/2 mile) ☐
    d. 9 to 10 blocks (3/4 mile) ☐
    e. 11-13 blocks (1 mile) ☐
    f. More than 2 miles to public transportation ☐
7. Is the exam room large enough for patient and additional person; including space for assistive equipment? ☐ Yes ☐ No
8. Is the exam room equipped with a chair scale available to persons with disabilities? ☐ Yes ☐ No

Please check the box if you have additional locations ☐

Visit www.hennepinhealth.org to access the provider location roster.

SERVICES AT THIS LOCATION *(check all that apply)*			
☐	ACUPUNCTURE	**CHEMICAL HEALTH** (options below)	
☐	AUDIOLOGY	☐	ASSESSMENT/DIAGNOSIS (RULE 25)
☐	CHILD AND TEEN CHECKUPS	☐	IP HOSPITAL TREATMENT
☐	CLINIC SVCS	☐	OP METHADONE TREATMENT
	CULTURALLY SPECIFIC SVCS (PLEASE SPECIFY)	☐	OP TREATMENT
☐	DIABETIES MANAGEMENT	☐	RESIDENTIAL NON-HOSPITAL TREATMENT
☐	DIAGNOSTICS	☐	OTHER (PLEASE SPECIFY)
☐	DOULA SVCS	**MENTAL HEALTH** (options below)	
☐	EATING DISORDERS	☐	ADULT REHABILITATIVE MENTAL HEALTH SERVICES (ARMHS)
☐	EYE EXAMS	☐	ASSERTIVE COMMUNITY TREATMENT (ACT)
☐	EYE WEAR – ONSITE	☐	BEHAVIORAL HEALTH HOME (BHH)
☐	GENDER HEALTH SVCS	☐	CERTIFIED PEER SPECIALIST
☐	HEALTH CARE HOME	☐	CHILDREN'S MENTAL HEALTH
☐	HOSPICE	☐	DAY TREATMENT
☐	LGBTQ	☐	DIALECTICAL BEHAVIORAL THERAPY
☐	DME (PLEASE SPECIFY)	☐	EARLY INTENSIVE DEVELOPMENTAL AND BEHAVIORAL INTERVENTION (EIDBI)
☐	OCCUPATIONAL THERAPY	☐	IP TREATMENT
☐	PAIN MANAGEMENT	☐	INTENSIVE REHABILITATIVE MENTAL HEALTH SERVICES (IRTS)
☐	PHYSICAL THERAPY	☐	OP TREATMENT
☐	PRIMARY CARE CLINIC SVCS	☐	TARGETED CASE MANAGEMENT
☐	RESPIRATORY THERAPY	☐	OTHER (SPECIFY TYPE)
☐	SMOKING CESSATION	**TRANSPORTATION** (options below)	
☐	TELEMEDICINE	☐	EMERGENCY MEDICAL
☐	URGENT CARE	☐	PROTECTED TRANSPORTATION
☐	OTHER (PLEASE SPECIFY)	☐	SPECIALIZED MEDICAL TRANSPORTATION
		☐	CURB TO CURB SERVICE
		☐	DOOR THROUGH DOOR SERVICE
		☐	DOOR TO DOOR SERVICE
		☐	OTHER (PLEASE SPECIFY)

CONTACT INFORMATION			
Contracting and Correspondence Mailing Street Address ☐ *Same as location address*	**City**	**State**	**Zip Code**
Contracting Contact *(name, email, phone)*			
Credentialing Contact *(name, email, phone)*			
Billing Contact *(name, email, phone)*			

Date of Form Completion

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