Non-Network Provider Information Form (PIF)

Note: If you are currently contracted with Hennepin Health or have received an offer to contract with Hennepin Health, complete the Network Provider Information Form (PIF) 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	**Fax Number**		

PRACTITIONER INFORMATION

Providers must be registered with the Minnesota Department of Human Services (DHS). Claims will be denied for all non-registered providers.

In the space below, please provide the practitioner information for those seeing Hennepin Health members.

Last name	**First name**	**Middle initial**	**Title**
DOB (MM/DD/YYYY)	**Type 1 individual NPI**	**SSN**	
Specialty	**State license #**		

Additional practitioner (if applicable)

Last name	**First name**	**Middle initial**	**Title**
DOB (MM/DD/YYYY)	**Type 1 individual NPI**	**SSN**	
Specialty	**State license #**		

CONTACT INFORMATION

Correspondence Mailing Street Address ☐ *Same as location address*	**City**	**State**	**Zip Code**
Billing contact *(name, email, phone)*			
Contact information of Business Owner: *(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!