

PHYSICIANS

HEALTH COLLABORATIVE

PO Box 347 ▪ Toledo, OH 43697

Phone: 419-251-0006

Fax: 419-251-0025

NETWORK PARTICIPATION – REQUEST FORM

Medical Practitioners who wish to become a participating provider for Physicians Health Collaborative should print and return this completed form to the network.

Upon receipt, a Network representative will call the contact person listed below to discuss network eligibility requirements. Once eligibility is confirmed, the applicable network agreements will be forwarded, which includes application credentialing requirements.

Submission of signed agreements and credentialing documents does not guarantee network participation. A determination notice will be sent following the review of the applying practitioners credentials by the appropriate network committee.

Today's Date: _____

Contact Person, Title _____ PH # _____

Physicians Full Name, Degree _____

Practice Name _____

Practice Address _____

Ph # _____ Fax # _____

Tax ID # _____ NPI # _____

Name of PHO Memberships (if applicable) _____

HOSPITAL PRIVILEGES: (Check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> Mercy Children's Hospital | <input type="checkbox"/> Mercy Hospital of Defiance |
| <input type="checkbox"/> Mercy Hospital of Tiffin | <input type="checkbox"/> Mercy Hospital of Willard |
| <input type="checkbox"/> St. Anne Mercy Hospital | <input type="checkbox"/> St. Charles Mercy Hospital |
| <input type="checkbox"/> St. Luke's Hospital | <input type="checkbox"/> St. Rita's Medical Center Hospital |
| <input type="checkbox"/> St. Vincent Mercy Medical Center | <input type="checkbox"/> Wood County Hospital |
| <input type="checkbox"/> Other _____ | |
| <input type="checkbox"/> Other _____ | |