Prominence℠ Health Plan

Letter of Intent

Yes, I/we do want to participate in the plans listed below:

❑Prominence HealthFirst Medicare Advantage ❑Prominence HealthFirst Commercial Product

Date: _____

Practitioner/Provider Name (Please Print): _____ NPI#: _____

Practitioner/Provider email: _____CAQH# _____

Specialty:_____ Board Certified: ❑Yes ❑No

Tax Identification Number: _____ Group NPI# (if applicable): _____

Name of Hospital(s) where privileged (if applicable): _____

Name of Group (if applicable): _____

Physical Address: _____

Phone: ( )_____ Fax: ( )_____

Second Address: _____

Phone: ( )_____ Fax: ( )_____

Mailing Address (if different from above): _____

Phone: ( )_____ Fax: ( )_____

Remittance Address (if different from above): _____

Specialty: _____ Second Specialty: _____

Contact Name & Title: _____ Phone: _____

Contact email: _____

A completed W-9 (Tax Identification Form) MUST be attached.

PLEASE EMAIL THE COMPLETED FORM WITH W-9 TO PHP-CONTRACTING@UHSINC.COM OR FAX TO 775.770.9009.