

REQUEST FOR PARTICIPATION FORM

Please fax form to 248-331-4473
 Attn: Provider Service Department

Provider is interested in participating as: (Please choose one)		PCP Facility	Specialist Ancillary	Allied Health
Provider Name			License State and Number	
Specialty			DEA Number	
Board Certified?	Yes No		NPI Number	
Has this Provider opted out of Medicare in the last 2 years?			Yes	No

Tax Identification Number (TIN)	
If applicable, please list all providers under the same TIN	

Name of Office			
Address			
City		State	
Zip		County	
Telephone		Fax	
Contact Person		Title	
E-Mail Address		Website	

Can one person sign on behalf of the group (i.e. have single signature authority)?	Yes	No
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