

PROVIDER CONTRACT APPLICATION

Completion of this application does not guarantee participation.

<p>Please mail, fax, or email the completed form to:</p> <p>South Country Health Alliance Attn: Contracting 110 West Fremont Street Owatonna, MN 55060 Phone: 218-316-3181 Fax: 507-444-7774 Email: jbarkhaus@mnscha.org</p>			
<p>PROVIDER INFORMATION</p>			
<p>Organization Legal Name and DBA</p>		<p>Provider Specialty</p>	
<p>List type of services offered by your organization:</p>			
<p>Are you a Medicare Provider? Yes <input type="checkbox"/> No <input type="checkbox"/></p>		<p>Are you a Medicaid Provider? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	
<p>Mailing Address:</p>	<p>City</p>	<p>State</p>	<p>Zip Code</p>
<p>Physical Address:</p>	<p>City</p>	<p>State</p>	<p>Zip Code</p>
<p>County:</p>	<p>Phone:</p>	<p>Fax:</p>	
<p>Contact Person:</p>	<p>Title:</p>	<p>Phone and extension:</p>	
<p>Contact email Address:</p>			
<p>Federal Tax ID#</p>	<p>Organization NPI Number:</p>		
<p>Do you have multiple locations? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, Please list.</p>			

All fields must be completed