HealthChoice
Delivering Healthcare Solutions.

Request for Application for participation in the HealthChoice Network

(Please note that HealthChoice is a joint venture of Methodist Lebonheur Healthcare and MetroCare Physicians. As such, it is in our charter to look to our owners for network services; however we must also provide a full complement of services to our members.)

Provider or Service Name: _____

Address: _____

Phone: _____ Fax: _____

Main Contact: _____ Email: _____

HealthChoice charges an annual participation fee. The amount of that fee will be based on the information provided on this application. If credentialing forms are sent to you for completion, the amount of this fee will be provided on that form. Fees are due and payable at the time the contract is signed.

Please answer the following questions and return the completed form to Rhonda McDonald via email rhonda.mcdonald@myhealthchoice.com or fax to 901-821-6787. This information will be presented to HealthChoice Administrative Management for consideration to apply for network participation.

1. Do you have accreditation by a nationally recognized body applicable to the services you provide? _____
2. Do you utilize HealthChoice affiliated providers?
    a. Utilize HealthChoice providers for referral services? _____
    b. Utilize HealthChoice providers for facility services (radiology, pathology, anesthesia, etc) or bill globally for these services? _____
3. What is the structure and ownership of the services for which you are requesting an application? _____
4. What services do you provide for which you are requesting an application? _____
5. Please explain how the services provided by your organization are a service that is unique and necessary for a comprehensive network? _____