Provider Participation Request

Colorado, Idaho, Nevada

Instructions: Please complete this form in its entirety and submit via email to the Provider Relations office for the state(s) listed below in which you practice.

- For Colorado, submit to: **COProviderRelations@selecthealth.org**
- For Idaho, submit to: **IDProviderRelations@selecthealth.org**
- For Nevada, submit to: **NVProviderRelations@selecthealth.org**

NOTE: A full provider roster and W9 will be required to begin the process to participate as a provider partner.

PRACTICE INFORMATION

How many office locations have you included with this request? (If more than two, please attach additional pages as needed.) _____

PRIMARY OFFICE

Clinic Name _____

Mailing Address _____

City/ST/Zip _____

Main Office Area Code/Phone _____

Practice Specialty _____

Number of Providers _____

List address in the directory(s) ○ Yes ○ No

Clinic Contact:

Name _____

Title _____

Phone _____

Email _____

Website _____

Telehealth:

Do you provide telehealth services? ○ Yes ○ No

ADDITIONAL OFFICE

Clinic Name _____

Mailing Address _____

City/ST/Zip _____

Main Office Area Code/Phone _____

Practice Specialty _____

Number of Providers _____

List address in the directory(s) ○ Yes ○ No

Clinic Contact:

Name _____

Title _____

Phone _____

Email _____

Website _____

Telehealth:

Do you provide telehealth services? ○ Yes ○ No

DISCLAIMER: Decisions on requests are based on Select Health membership access and business needs. All requests are subject to approval by the Credentialing Committee and the Select Health Practitioner Panel Strategy Committee (PPSC).