Print Form

Internal Use Only

___ Contract will be sent to provider

___ Contract not sent-no current network need

Date: _____

Request for Network Participation

Please Note: The ECOH networks cover the northern Illinois, southern Wisconsin, and eastern Iowa region.
Completion of this form does not guarantee acceptance as a network provider.

PROVIDER INFORMATION

Medical Practice / Facility Legal Name	DBA Name (if applicable)	Tax ID Number	Practice / Facility NPI#	Practice / Facility Phone Number
Practice / Facility Street Address	City	County	State / ZIP Code	Practice / Facility Fax Number
Individual Provider-Last Name	First Name / Middle Initial	Degree	NPI#	Specialty
License #	Hospital Affiliation(s)	Bill Type: 1500 or UB		
If multiple providers, please list below				
Individual Provider-Last Name	First Name / Middle Initial	Degree	NPI#	Specialty
License #	Hospital Affiliation(s)	Bill Type: 1500 or UB		
Individual Provider-Last Name	First Name / Middle Initial	Degree	NPI#	Specialty
License #	Hospital Affiliation(s)	Bill Type: 1500 or UB		
Contracting Contact: Name	Email	Phone		**Submitting multiple forms for:** Locations Providers

Instructions:

If the practice / facility has multiple locations, please fill out a *Request for Network Participation* form for each location listing each provider at that location. If there are more providers for the practice than can be submitted on one form, please submit multiple, fully completed forms to accommodate the number of providers. Please indicate the submission of multiple forms in the box above.

Please submit completed *Request for Network Participation* form(s), along with a W-9 form via fax at 815-397-2790 or email at HFNProviderUpdates@stratose.com. If you have any questions, please contact Customer Service at 800-990-3204.