



8101 W. Sam Houston Pkwy S. Houston, TX 77072

Fax: 832-553-3418

PRACTITIONER INTEREST FORM

PLEASE PRINT

Date:	Contact Person:	
Practitioner Name:	NPI:	
Telephone #:	Fax #:	
County:	Desired Role: ☐ PCP ☐ Specialist ☐ Behavioral Health	
Are you still in Residency? ☐ Yes ☐ No If Yes, expected Residency completion date: <u>Applications will not be accepted prior to 30 days of Residency Completion.</u>		
Practitioner's Physical Address:	Practitioner's Mailing Address (if different than Physical):	
Are you joining an existing group of practitioners who are currently on plan with RPO? ☐ Yes ☐ No Group Name: Group Tax ID: List call coverage practitioner(s):		
Practitioner's Medicare #:	Practitioner's Medicaid #:	
At what hospitals do you have admitting privileges (if applicable):		
Primary Specialty:	Are you board certified in this specialty? ☐ Yes ☐ No	
Specialty #2:	Are you board certified in this specialty? ☐ Yes ☐ No	

Note: Submission of this interest form does not guarantee acceptance by the plan.

For RPO Use Only:		
Rec'd:	☐ Send to Sub-committee ☐ Send to Delegate	Date Interest Form Sent to Provider Relations:
Rec'd: Initials:		
☐ Application Request Denied	Reason Application Request Denied:	Date Denial Letter Sent:

THIS FORM CAN BE DOWNLOADED, PRINTED, AND FAXED TO 832-553-3418. IF THIS FORM IS RETURNED WITHOUT ALL REQUIRED QUESTIONS ANSWERED, IT WILL NOT BE PROCESSED.