Renaissance Physicians

CARE THAT REVOLVES AROUND YOU.

Phone: 832-553-3300 2900 North Loop West, Suite 1300 Houston, TX 77092 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:**

APPLICATIONS WILL NOT BE ACCEPTED PRIOR TO 30 DAYS OF RESIDENCY COMPLETION

Practitioner's Physical Address:	**Practitioner's Mailing Address** (if different from Physical Address):

Are you joining an existing group of practitioners who are currently on plan with [Plan Name]? ☐ 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 eligible in this specialty?:** ☐ Yes ☐ No

NOTE: SUBMISSION OF INTEREST FORM DOES NOT GUARANTEE ACCEPTANCE BY THE PLAN.

For [Plan Name] Use Only:

Rec'd:	☐ Send to Sub-committeee ☐ Send to Delegate	Date Interest Form Sent to Provider Relations:
Rev'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 FORM IS RETURNED WITHOUT ALL REQUIRED QUESTIONS ANSWERED, IT WILL NOT BE PROCESSED. Should you have questions or concerns please call 832-553-3300, and request to speak with a practitioner provider relations representative.