DirectNet
Healthy Together

NEW PRACTICE INTERESTED IN PARTICIPATION

Please provide the following information:

1. Practice Name _____
2. Practice Tax ID _____
3. Provider(s) Names _____
4. Physical Address _____
5. Mailing Address _____
   (If different from above)
6. Primary Specialty _____
7. Telephone # _____
8. Fax # _____
9. Practice Contact Name _____
10. Practice Contact Email _____
11. Fee Schedule Request: Up to twenty-five (25) CPTs applicable for the provider specialty can be listed below so that we can provide a current reimbursement schedule. Codes may be indicated below or emailed in Excel spreadsheet.

_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Please email the completed form to lmorris@DirectNetLLC.com OR fax to 828-485-4334

After receipt of the above information, a Letter of Agreement, including Fee Schedule for the applicable specialty and a Provider Information Datasheet will be forwarded to you for completion and return to DirectNet.

Upon your return of the signed Letter of Agreement, Information Datasheet and requested item(s) on datasheet, your request for participation will be processed and you will be notified via email of your participation effective date with DirectNet.