ONEHEALTH
LETTER OF INTEREST
INFORMATION FORM

GROUP NAME: _____ **TAX ID NUMBER:** _____

Address	City	State	Zip	Phone	Fax
Additional Address	City	State	Zip	Phone	Fax

___ Please see attached information listing all of our locations.

	PROVIDER NAME	PROVIDER SPECIALTY (One specialty per provider)	LANGUAGES SPOKEN	HOSPITAL PRIVILEGES OR AFFILIATIONS
1)				
2)				
3)				
4)				
5)				

___ Please see attached roster providing all of the above listed information.

Contact person for credentialing: _____ **E-mail address:** _____

Circle below to appropriately reflects your type of practice -

Solo Practice: Y or N **Group Practice:** Y or N **Inpatient Services Only:** Y or N

BRIEFLY DESCRIBE STAFFING:

1) Do/will you have physician assistants (PAs) working in your practice under provider's tax i.d. number? If so, please list:

_____

2) Please tell us how many nurses you have/will have on staff. _____

3) Please list languages, other than English, spoken by staff members (non-physicians).

_____

4) If the provider's specialty is Anesthesiology, is it the provider's intent to provide Pain Management services? Y or N
In accordance with One Health guidelines, those physicians who desire to hold themselves out as Pain Management/Medicine Specialists must submit verifiable documentation which demonstrates the provider has satisfactorily completed a 12-month, ACGME-accredited Pain Medicine Fellowship, or hold ABMS Board Certification in the Specialty of Pain Medicine.

FAX BACK TO: 775-982-8003
ATTENTION: Contracting