Provider Interest Form

Provider Name (W-9)

D/B/A

Type of Services Provided

Tax Identification Number | **NPI**

Medicaid Provider? Yes/No | **Hospital Affiliations (if applicable)**

Primary Address

City | **State** | **Zip Code** | **County**

Contact Name | **Contact Title**

Contact Phone # | **Contact Fax #** | **Contact Email**

Plans interested in:

- ☐ Commercial[1]
- ☐ Medicaid (STAR[12] & STAR+PLUS[2])
- ☐ Medicare
- ☐ CHIP[12]

Additional information: _____ *# of Locations* _____ *# of Providers*

Thank you for your interest in becoming FirstCare Health Plans provider. Please submit your Provider Interest Form, along with your W-9, to FirstCare Health Plans at:

- Email: contracting@firstcare.com
- Fax: 512-257-6000

Please make sure this form is completely filled out and legible. Please return this form along with a complete current and signed W-9. This form does not guarantee participation in the network. Applicants must meet all credentialing criteria and other participatory criteria.

[1]Currently in the FirstCare product portfolio.
[2]Providers must have a valid TPI in order to participate in the Medicaid and CHIP networks.

12940 N Hwy 183 Austin, Texas 78750 | 512-257-6000 | FirstCare.com