Medicare Advantage
Facility/Ancillary Network Interest Form

Submit this completed form along with a copy of your group's roster to the email address that corresponds to your market (see page 3). Answer all fields to ensure processing.

Submission of this form does not guarantee acceptance. Your request will be reviewed based on network need and current availability of services. Allow up to 90 days to receive a response. All providers are subject to HealthSpring credentialing requirements and applicable state and federal guidelines.

If you're seeking to join an existing provider group that has an active contract with HealthSpring, reach out to your designated Provider Relations contact rather than completing this form.

Behavioral health providers: Visit **Evernorth® Behavioral Health provider network** rather than completing this form.

Routine vision services are managed through our vision vendor, EyeMed. For more information about EyeMed, or to join their network, please **visit their website**.

Office contact information

HealthSpring will use this information for any questions, concerns or responses regarding this form.

Date / /	Name		
Email		Phone	Fax

Facility/ancillary information

Corporate name		Operating DBA name	
National Provider Identifier	Tax ID	Medicare	Medicaid
Are you accredited? ☐ Yes ☐ No	If yes, list the accrediting entity		

Practice locations

Only list locations where you actively practice.

Location 1 Address		
City	State	ZIP
Office hours	Counties serviced	
Location 2 Address		
City	State	ZIP
Office hours	Counties serviced	

Practice areas covered

☐ AL ☐ AR ☐ CO ☐ CT ☐ DC ☐ DE ☐ FL ☐ GA ☐ IL ☐ KS ☐ MD ☐ MO ☐ MS ☐ NC ☐ NM
☐ NJ ☐ OH ☐ OK ☐ OR ☐ SC ☐ TN ☐ TX ☐ UT ☐ VT ☐ WA

Facility/ancillary specifications

☐ **Hospital** ☐ Acute ☐ Inpatient ☐ Long-term care
☐ **Transplant program** ☐ Kidney ☐ Heart ☐ Pancreas ☐ Liver ☐ Lung
☐ Critical care services – Intensive care units
☐ Cancer center
☐ Cardiac catheterization services
☐ **Cardiac program** ☐ Surgery ☐ Monitoring ☐ Testing
☐ Chiropractor
☐ Mammography center
☐ Outpatient or ambulatory surgery center
☐ **Rehab facility** ☐ Inpatient ☐ Outpatient
☐ **Diagnostic** ☐ Testing ☐ Radiology
☐ **Therapy** ☐ Physical ☐ Occupational ☐ Speech language
☐ Respiratory ☐ Massage
☐ Ambulance or transportation service
☐ **Skilled nursing facility** ☐ Vent ☐ Onsite dialysis

☐ Endoscopy center
☐ Federally qualified health center
☐ Radiology
☐ Sleep clinic
☐ Infusion therapy services
☐ Dialysis center
☐ Durable medical equipment
☐ Orthotics
☐ Prosthetics
☐ Home health agency
☐ Hearing aid provider
☐ Urgent care center
☐ Laboratory services
☐ Other

Billing information

This information should match your W-9.

Address			
City		State	ZIP
Phone	Fax	NPI	Tax ID
Group name		Group DBA name	

Market email addresses

Submit this completed form along with a copy of your group's roster to the email address that corresponds to your market.

Market	Email
Alabama, North Florida, South Mississippi	**al_provinterest@healthspring.com**
Arizona	**AZMANetworkOperations@healthspring.com**
Central Florida	**centralfloridaproviders@healthspring.com**
Colorado, New Mexico, Oregon, Utah and Washington	**co_provider_interest@healthspring.com**
Conneticut	**ctmarketprovidercommunications@healthspring.com**
Delaware, Maryland, New Jersey, Pennsylvania, Virginia and Washington, D.C.	**Provider_Intake_Form_MA/PA@healthspring.com**
Georgia	**GeorgiaProvider@healthspring.com**
Illinois	**ILProviderData@healthspring.com**
Kansas City, Missouri	**kansascityprovider@healthspring.com**
New York	**NYMarketProviderCommunications@healthspring.com**
North Carolina and South Carolina	**ca_business_support@healthspring.com**
Ohio	**OHProviderData@healthspring.com**
Oklahoma and Texas	**TXMAContracting@healthspring.com**
South Florida	**SFLMedicareproviders@healthspring.com**
St. Louis, Missouri	**StLouisProvider@healthspring.com**
Tennessee and Arkansas	**tn_contract_administration@healthspring.com**
Vermont	**NewEnglandMarketProviderCommunications@healthspring.com**