

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? <input type="checkbox"/> Yes <input type="checkbox"/> 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

- | | |
|---|--|
| <input type="checkbox"/> Hospital <input type="checkbox"/> Acute <input type="checkbox"/> Inpatient <input type="checkbox"/> Long-term care
<input type="checkbox"/> Transplant program <input type="checkbox"/> Kidney <input type="checkbox"/> Heart <input type="checkbox"/> Pancreas <input type="checkbox"/> Liver <input type="checkbox"/> Lung
<input type="checkbox"/> Critical care services – Intensive care units
<input type="checkbox"/> Cancer center
<input type="checkbox"/> Cardiac catheterization services
<input type="checkbox"/> Cardiac program <input type="checkbox"/> Surgery <input type="checkbox"/> Monitoring <input type="checkbox"/> Testing
<input type="checkbox"/> Chiropractor
<input type="checkbox"/> Mammography center
<input type="checkbox"/> Outpatient or ambulatory surgery center
<input type="checkbox"/> Rehab facility <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient
<input type="checkbox"/> Diagnostic <input type="checkbox"/> Testing <input type="checkbox"/> Radiology
<input type="checkbox"/> Therapy <input type="checkbox"/> Physical <input type="checkbox"/> Occupational <input type="checkbox"/> Speech language
<input type="checkbox"/> Respiratory <input type="checkbox"/> Massage
<input type="checkbox"/> Ambulance or transportation service
<input type="checkbox"/> Skilled nursing facility <input type="checkbox"/> Vent <input type="checkbox"/> Onsite dialysis | <input type="checkbox"/> Endoscopy center
<input type="checkbox"/> Federally qualified health center
<input type="checkbox"/> Radiology
<input type="checkbox"/> Sleep clinic
<input type="checkbox"/> Infusion therapy services
<input type="checkbox"/> Dialysis center
<input type="checkbox"/> Durable medical equipment
<input type="checkbox"/> Orthotics
<input type="checkbox"/> Prosthetics
<input type="checkbox"/> Home health agency
<input type="checkbox"/> Hearing aid provider
<input type="checkbox"/> Urgent care center
<input type="checkbox"/> Laboratory services
<input type="checkbox"/> Other <input style="width: 150px; height: 15px;" type="text"/> |
|---|--|

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 and New Mexico	AZMANetworkOperations@HealthSpring.com
Central Florida	CentralFloridaProviders@HealthSpring.com
Colorado, Nevada, Oregon, Utah and Washington	CO_Provider_Interest@HealthSpring.com
Connecticut	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 and Kentucky	OHProviderInquiry@HealthSpring.com
South Florida	SFLMedicareProviders@HealthSpring.com
St. Louis, Missouri	StLouisProvider@HealthSpring.com
Tennessee and Arkansas	TN_Contract_Administration@HealthSpring.com
Texas and Oklahoma	TXMAContracting@HealthSpring.com
Vermont	NewEnglandMarketProviderCommunications@HealthSpring.com