



BROMENN PROVIDER NETWORK

Opening doors. Touching lives.

Affiliated Provider Inquiry
REQUEST to Join the Network
(This is NOT an Application)

On Date: _____ Provider Contact Person _____

SECTION A

Name: _____ Primary Specialty: _____
 Practice Name: _____ Subspecialty(s): _____
 Address: _____ Tax ID# _____
 City: _____ License # _____ DEA # _____
 State: _____ ZIP: _____ Malpractice Coverage \$ _____
 Phone: _____ FAX: _____ Date of Birth: _____
 Are you Board Certified? (Y/N) _____ If Yes, What Specialty(s) _____

SECTION B

Are you an independent provider?
 If No, list names of the other providers
 In your practice: _____
 Other Office Locations? (Y/N) _____ Where? _____
 How often are you there? _____
 Have you ever been affiliated or applied for
 affiliation to the BPN? If Yes, History: _____
 At what hospitals/ASC's do you have privileges? _____
 If PCP, how many patients do you currently have? _____ Do you accept new patients? _____
 Who covers for you in your practice? _____

SECTION C

What other Provider Networks (PHO, IPA, etc) do you belong or are applying ? _____
 Do you have a financial relationship with any other HealthCare Organization/Entity ? NO _____ YES _____
 Please explain: _____

BPN Office Use Only

Approved: Approved Reason: _____ Date: _____
 Pending: Pending Reason: _____ Date: _____
 Denied: Denied Reason: _____ Date: _____

Medical Director approval signature for addition to Network: _____

Letter sent to Provider: _____ Date: _____