HealthyPrice

Fields marked by an asterisk (*) are required.

HEALTHYPRICE PROVIDER MEMBER APPLICATION

* Today's Date: _____ (mm/dd/yyyy)

* Last Name: _____

* First Name: _____

Middle Initial: _____

* Date of Birth: _____ (mm/dd/yyyy)

* Email Address: _____ (example@domain.com)

* Phone Number: _____ (123-456-7890)

* Fax Number: _____ (123-456-7890)

" Tax ID Type: (check the box)
- ☐ E - Employee Identification Number or
- ☐ S - Social Security Number

* Tax ID Number: _____ (do not include dashes or spaces)

* Practice/Specialty: (check the box(es))

- ☐ Allergy and Immunology
- ☐ CAT Scan (Radiology)
- ☐ Cardiology
- ☐ Dermatology
- ☐ Ear, Nose, Throat
- ☐ Endocrinology
- ☐ Family & General Practice
- ☐ Gastroenterology
- ☐ General Surgery
- ☐ Gynecology and Obstetrics
- ☐ Internal Medicine
- ☐ MRI (Radiology)
- ☐ Neurology
- ☐ Ophthalmology
- ☐ Orthopedics
- ☐ Pain Management
- ☐ Pediatrics
- ☐ Podiatry
- ☐ Pulmonary Medicine
- ☐ Rheumatology
- ☐ Ultrasound
- ☐ Urology
- ☐ X-Ray (Radiology)

* Medical School: _____

* Type of Degree: _____

* Year Graduated: _____ (yyyy)

* State Medical License Issued In: _____

* Medical License #: _____

* License Type: _____

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Fields marked by an asterisk (*) are required.

HEALTHYPRICE PROVIDER MEMBER APPLICATION (continued)

Your Practice/Service Location Information

Name of Practice: _____

* Street Address: _____

_____

* City: _____

* State: _____

* Zip Code: _____ (12345-1234)

Your Mailing Address (if different):

Name: _____

Street Address: _____

_____

City: _____

State: _____

Zip Code: _____ (12345-1234)

Other Information:

* Hospital Affiliations: _____ Usage %: _____

_____ Usage %: _____

_____ Usage %: _____

* Doctor References:

Last Name: _____
First Name: _____
Phone Number: _____ (123-456-7890)

Last Name: _____
First Name: _____
Phone Number: _____ (123-456-7890)

HealthyPrice

Fields marked by an asterisk (*) are required.

HEALTHYPRICE PROVIDER MEMBER APPLICATION (continued)

Last Name:
First Name:
Phone Number: (123-456-7890)

Last Name:
First Name:
Phone Number: (123-456-7890)

Last Name:
First Name:
Phone Number: (123-456-7890)

* Insurance Carriers
You're a Member Of:

Name of Company:

Name of Company:

Name of Company:

Name of Company:

Name of Company:

* Malpractice Insurance:

Name of Carrier:

Policy #:

Expiration Date: (mm/dd/yyyy)