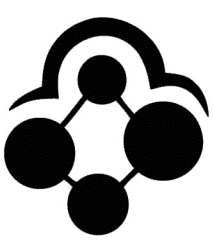

Healthcare Networks of America
RESTORING PHYSICIAN PROSPERITY

Provider: _____

_____

_____

Fax Number: _____

CREDENTIALING FORM
Deadline Date: _____

Federal Tax ID Number: _____

National Provider Identifier #: _____

Malpractice Carrier:_____ Exp.: _____

State License Number: Exp.: _____

DEA Certificate #: Exp.: _____

Credentialing Contact Email: _____

Doctor/Provider Email: _____

Phone #: _____ FAX #: _____

Website: _____

Annual Network Participation $145

Check #: MasterCard/Visa (American Express (

Card Number: _____

Exp. Date: _____ 3 or 4 digit security code: _____

I authorize the above card to be charged for my membership fee.

To obtain a copy of our fee schedule/health plan list please e-mail us at providerrelations@hna-net.com

You consent to us contacting you using all channels of communication and for all purposes. We will use the contact information you provide to us. This may include text messages, automatic telephone dialing systems, prerecorded voice and/or fax. We do not sell or distribute our lists. This information is used for internal purposes only.

Signature _____ **Date** _____

PO BOX 71717, PHOENIX, ARIZONA 85050
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