SENDERO HEALTH PLANS

Provider Interest Form

Provider Name: _____ DBA: _____

Specialty: _____

Primary Address: _____

City_____Zip:_____County:_____

Office Phone:_____Office Fax:_____

Contact Person:_____Contact Phone:_____

Contact Email: _____

Hospital Affiliations: _____

Satellite Location(s)_____

Tax ID: _____

NPI:_____TPI: _____

Do you provide services in the Travis Service Delivery Area (Burnet, Bastrop, Travis, Fayette, Hays, Williamson, Lee, and Caldwell Counties)? ☐ Yes ☐ No

Medicaid Provider: ☐Yes ☐No

ECI Provider: ☐Yes ☐No

Plans Interested in: ☐ STAR ☐ CHIP ☐ IdealCare (Marketplace)

Type of Provider: ☐ Group ☐ Individual Provider

Thank you for your interest in becoming a provider with Sendero Health Plans. Please submit your Provider Interest Form to:

Sendero Health Plans FAX: (512) 901-9704 Email: providers@senderohealth.com

Date: _____