FORM 012015ACP

Adding an Affiliate or Partner Provider to an ACP Network

Provider Name:	
Provider Tax Identification Number (TIN):	
Affiliate or Partner?	
Effective Date: (ACP Network assigns anticipated effective date)	
Is the Provider in more than one Network? If so, please confirm whether exclusive to your Network for attribution	
Approximate Number of Health Care Providers: Approximate Number of PCPs: Approximate Number of Specialists: Name(s) of Hospitals:	
Name(s) of Service Area Counties to be Covered:	

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