PLAN DE SALUD
MENONITA

Provider Network Solutions Puerto Rico

Provider Network Solutions of Puerto Rico LLC
Contracting Request Form

Instructions:

1. Please fill out all sections of this form.
2. If a section does not apply to you, mark it as "N/A".
3. Ensure all information is accurate and up to date.
4. Send the completed form to providerservices@pns-pr.com

I. Line of Business: *Please, select the Line of Business in order to be considered to the applicable Contracting Process.*

Select at least one:

- ☐ Commercial
- ☐ Vital (to be Contracted, Billing and Rendering Providers Relation shall have a PEP/ PRMMIS Active and Valid Medicaid ID Number)

II. Billing Information

Legal Name:	**Doing Business As:** ☐ N/A
Billing Tax ID or Social Security Number:	**Billing NPI Number:**
Billing Email:	**Billing Phone Number:**
Mailing Address:	**Specialty:**

III. Rendering Information

Legal Full Name (If Individual, include Full Name(s) and both Last Names):	**Doing Business As:** ☐ N/A

Provider Network Solutions of Puerto Rico LLC
Contracting Request Form

Date of Birth (mm/dd/yyyy): ☐ N/A (No Practitioners)	**Practitioner or SARAF License Number:**
Specialty: ______________________ ☐ Adult ☐ Pediatric	**Rendering Tax ID or Social Security Number:**
Rendering NPI Number:	**Provider Email:**
Do you provide Telemedicine Service? ☐ YES ☐ NO	**Have you complete Cultural Competency Training?** ☐ YES ☐ NO

IV. Rendering Practice Locations

Primary Location

Location Type: ☐ Private Practice ☐ Group Practice/Clinic ☐ Hospital-Based Physician ☐ Medical Clearance ☐ Government Facility ☐ Federally Qualified Health Center ☐ Ryann White Program.	
Physical Address:	
Accept New Patients? ☐ YES ☐ NO	**This Physical Address is Registered in PEP/PRMMIS?** ☐ YES ☐ NO
Phone Number:	**Alternate Phone Number:** ☐ N/A

Primary Location Office Service Hours						
Sunday ☐ N/A	**Monday** ☐ N/A	**Tuesday** ☐ N/A	**Wednesday** ☐ N/A	**Thursday** ☐ N/A	**Friday** ☐ N/A	**Saturday** ☐ N/A

PLAN DE SALUD MENONITA

Provider Network Solutions Puerto Rico

Provider Network Solutions of Puerto Rico LLC
Contracting Request Form

Secondary Location (if applicable) ☐ N/A

Location Type: ☐ Private Practice ☐ Group Practice/Clinic ☐ Hospital-Based Physician ☐ Medical Clearance ☐ Government Facility ☐ Federally Qualified Health Center ☐ Ryann White Program.

Physical Address:

Accept New Patients? ☐ YES ☐ NO	**This Physical Address is Registered in PEP/PRMMIS?** ☐ YES ☐ NO
Phone Number:	**Alternate Phone Number:** ☐ N/A

Second Location Office Service Hours

Sunday ☐ N/A	Monday ☐ N/A	Tuesday ☐ N/A	Wednesday ☐ N/A	Thursday ☐ N/A	Friday ☐ N/A	Saturday ☐ N/A

Third Location (if applicable) ☐ N/A

Location Type: ☐ Private Practice ☐ Group Practice/Clinic ☐ Hospital-Based Physician ☐ Medical Clearance ☐ Government Facility ☐ Federally Qualified Health Center ☐ Ryann White Program.

Physical Address:

Accept New Patients? ☐ YES ☐ NO	**This Physical Address is Registered in PEP/PRMMIS?** ☐ YES ☐ NO
Phone Number:	**Alternate Phone Number:** ☐ N/A

Sunday ☐ N/A	Monday ☐ N/A	Tuesday ☐ N/A	Wednesday ☐ N/A	Thursday ☐ N/A	Friday ☐ N/A	Saturday ☐ N/A

PLAN DE SALUD MENONITA

Provider Network Solutions Puerto Rico

Provider Network Solutions of Puerto Rico LLC
Contracting Request Form

V. Signature

Authorized Official Full Name • *Include Authorized Official Full Name.*	
Authorized Official Signature: • *Sign the form.*	
Date: • *Enter the date of signing.*	