



**Provider Request for Participation**

Applicant Name: \_\_\_\_\_  
First Middle Last Title

Legal Business Name: \_\_\_\_\_  
 Physical Address: \_\_\_\_\_  
City County State Zip

**\*\*\* YOU MUST SUBMIT A COPY OF CURRENT W-9 WITH THIS FORM\*\*\***

Specialty: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

- If a Physician (M.D./D.O.), are you board certified through an ABMS Board?..... Yes  No
- If not board certified, when were you eligible?..... \_\_\_\_\_
- If a Podiatrist, are you board certified through ABPS or other source?..... Yes  No
- If not, when were you eligible?..... \_\_\_\_\_
- If a DME provider, are you licensed in Illinois?..... Yes  No
- If a Doctor of Optometry, are you TPA & DPA Certified?.. Yes  No
- If a Facility provider, are you JCAHO Accredited?..... Yes  No
- Do you have at least \$1million ea. occ./\$3million agg. of Professional Liability coverage?..... Yes  No

| Hospital Privileges | Hospital | Status |
|---------------------|----------|--------|
| _____               | _____    | _____  |
| _____               | _____    | _____  |

Ownership:

|       |  |   |
|-------|--|---|
| _____ | <input type="checkbox"/> Physician Owned                             | <input type="checkbox"/> Hospital Owned |
| _____ | <input type="checkbox"/> Owned Component of Integrated Health System |   |
|       | <input type="checkbox"/> Other (explain)                             |   |

\_\_\_\_\_ Title \_\_\_\_\_ Phone \_\_\_\_\_  
Person Completing Form

**Please send completed form to: Fax: 309-693-3461 or Mail: 1420 W. Pioneer Parkway, Peoria, IL 61615**