

Teachers Health Trust Network

The Teachers Health Trust has developed its own PPO Medical Network for its members.

Benefits of joining the Teachers Health Trust Network:

- No fees to join
- Simple credentialing process
- Contract language applicable to the Teachers Health Trust
- Annual newsletter to update providers on new information from the Trust

Participation in the Trust network is not automatic. Enclosed is an information form to be completed by your office to indicate whether you are or are not interested in participating in the Teachers Health Trust Network.

- If you are interested and would like to receive a contract proposal, complete the form, marking the appropriate box, and return the interest form to the Trust either via facsimile at (702) 866-6121 or postal service at P.O. Box 96238, Las Vegas, Nevada 89193-6238, Attention: Provider Relations Department. Contract proposals and credentialing forms will be forwarded to you after your interest form is received.
- If you are not interested in participating in the network, please take the time to complete the information on the form and return it to the Trust. This will ensure that the Trust has the most up-to-date information on your practice.

If you have any questions or require additional information, please contact the Provider Relations Department at (702) 866-6120. You may also e-mail the Provider Relations Department at providerrelations@teachershealthtrust.org.



For Teachers By Teachers

TEACHERS HEALTH TRUST PROVIDER INFORMATION / INTEREST FORM

Copies of this form may be made if additional copies are required for your practice
 Questions regarding this form should be submitted to providerrelations@teachershealthtrust.org.

Provider TIN: _____	Specialty _____
Group/Practice Name (DBA): _____	
Name as identified by the IRS: _____	
<p>Names of All Providers in the Practice and their credentials (<i>include Physician Assistants, Nurse Practitioners and any other provider that may bill the Trust for services rendered in your office</i>) Please indicate which location each provider primarily works by listing the appropriate number from the physical location boxes below next to the providers name (for example, John Smith, 2)</p>	
_____	_____
_____	_____
_____	_____

Contact Information for Your Practice

Credentiaing Information	Remit Address:
_____	_____
_____	_____
Phone/Fax Numbers:	Phone/Fax Numbers:
_____	_____
<i>Phone</i> <i>Fax</i>	<i>Phone</i> <i>Fax</i>
Primary Contact: _____	Primary Contact: _____

Physical Locations and Phone Numbers of all Offices in Your Practice

(If additional space is needed, you may copy this form or submit on a separate sheet of paper)

1. Address _____ _____
Phone _____

2. Address _____ _____
Phone _____

3. Address _____ _____
Phone _____

4. Address _____ _____
Phone _____

I am interested in contracting directly with Teachers Health Trust. Please send me a contract proposal and credentialing form. If you would like the contract sent via email, please provide your email address

I am NOT interested in contracting directly with the Teachers Health Trust.

Printed Name of Person Preparing this Form

Signature

Date

FOR OFFICE USE ONLY

Date Received by Provider Relations: _____ Initials: _____ Date Contract Mailed to Provider: _____ Initials: _____