Request to Join the Essence (EHI) Provider Network

Please print form and complete as instructed. Please use the Notes section at the bottom if there is additional information that needs to be conveyed. Email your request to newprovideringuiry@lumeris.com. Your request will be reviewed to determine if there is a network need for your specialty. You will receive a response within 4-8 weeks. Thank you for your interest.

Date: _____ Provider Specialty:_____Tax ID*:_____

* If the entity/practice has multiple TINs, please indicate TIN and the legal name in the Notes section below.

Group's Legal and DBA Name (if applicable) as on W-9: _____

_____

Entity/Group NPI (if not applicable indicate NA):_____

Contact Person's Name:_____Phone:_____Email:_____

Contact Person's Position: _____Entity's Website:_____

If group is an Ancillary provider (e.g. ASC, Diagnostic, DME/O&P, Home Health, Lab, SNF, etc.) please complete this section.

Address:_____City:_____State: _____ Zip: _____

Phone:_____Fax:_____County (if in EHI service area)*: _____

* EHI service area- MO counties of St. Louis, St. Louis City, St. Charles, Jefferson, Warren, Lincoln, Crawford, Franklin and Boone and IL counties of Madison, St. Clair and Monroe. If Ancillary provider has multiple addresses that services all or some of these counties, please indicate in Notes section below or attach list.

If practice is an individual or group of practitioners such as a specialist, PT/OT/ST, or a PCP please complete this section. Nurse Practitioners and Physician Assistants MUST be part of an EHI contracted specialist group and TIN in order to participate.

Primary Office Address:_____City:_____

State: _____ Zip: _____Phone:_____Fax:_____County:_____

Provider Name and Professional Title:_____ NPI:_____

Provider Name and Professional Title:_____ NPI:_____

Provider Name and Professional Title:_____ NPI:_____

Provider Name and Professional Title*:_____ NPI:_____

If any of these providers currently or recently practiced with another group already participating in Essence, indicate name(s):

_____

Secondary Office Address*:_____City:_____

State: _____ Zip: _____ Phone:_____Fax:_____County:_____

* If there are additional providers or addresses, please list the same information in Notes section below or attach list.

Notes: _____

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