NLPHO / PEOPLES HEALTH NETWORK ENROLLMENT FORM

Reimbursement will be 100% of current Medicare

☐ I DO wish to participate in the Peoples Health Medicare Advantage network through NLPHO.

☐ I do **NOT** wish to participate in the People Health Medicare Advantage network through NLPHO.

I am currently accepting new Medicare patients: ☐ *Yes* ☐ *No*

________________________	________________________
Group Practice Name (please print)	**Provider (or Authorized Signature)**
________________________	________________________
Federal TIN #	**Date**

Please list provider names (for this contract: **MDs, DOs, NPs** and **PAs** only):

________________________	________________________
Provider Name (please print)	Provider Name (please print)
________________________	________________________
Provider Name (please print)	Provider Name (please print)
________________________	________________________
Provider Name (please print)	Provider Name (please print)
________________________	________________________
Provider Name (please print)	Provider Name (please print)
________________________	________________________
Provider Name (please print)	Provider Name (please print)
________________________	________________________
Provider Name (please print)	Provider Name (please print)

Please sign this form and return by:

Fax to (318) 387-7452 / Email to monica.pittman@fmolhs.org Or mail to:
Northeast Louisiana Physician Hospital Organization
1900 North 18th Street, Suite 304, Monroe, LA 71201
Call (318) 387-7358 with questions

- -