Office Information	
Office Name:	Office Contact:
Street Address:	City/State/Zip Code:
Phone:	Email:
Fax:	NPI:
Please note: We need your staff roster and W-9 to be able to process the network application. Please submit with this application.	
Billing and Remittance Information	
Payee Name:	Tax ID #:
Street Address:	City/State/Zip Code:
Contact Name:	Phone:
Email:	Fax:
Credentialing Information	
Contact Name:	Email:
Practice Details	
Languages Spoken:	Patient Age Range:
Services Provided:	
Other Information:	

Information

- Please complete the above fields and submit this form with a copy of the W-9 and your staff roster. You may submit this form via fax or email with the information below.
  - Email: providerservices@holistahealth.com
  - Fax: 866-231-6344
- If you have more than one location, please submit a network application for each location.
- Once submitted, it may take up to 7 business days for a response. Your response will be in the form of an email.
- Questions may be directed to 888-560-6855, Monday – Friday 8am to 4pm CT.