NLPHO / DIGNITY HEALTH PLAN
ENROLLMENT FORM

Reimbursement will be 102% of current Medicare

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

☐ I do **NOT** wish to participate in the Dignity 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)

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

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

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

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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 703
Monroe, LA 71201
Call (318) 387-7358 or (800) 937-0970 with questions