



HEALTH CARE PROVIDER PARTICIPATION FORM

INSTRUCTIONS: Form to be completed by health care provider and faxed to Anchorage Project Access at (907) 646-0542.

NAME OF PROVIDER: _____

GROUP NAME: _____

SCOPE OF PRACTICE/SPECIALTY: _____

FACILITY ADDRESS: _____

PHONE: _____ FAX: _____ EMAIL: _____

MANAGER'S NAME: _____

MANAGER'S TITLE: _____

MANAGER'S PHONE: _____ FAX: _____ EMAIL: _____

PREFERRED LAB SERVICES: _____

Yes, I'll do my part to make Anchorage Project Access a success.

Here's my participation pledge:

(A pledge consists of a completed medical treatment plan for each patient. There may be multiple follow-up appointments and services related to the completion of each treatment plan.)

_____ I will accept _____ Anchorage Project Access referral(s) per month or

_____ I will accept _____ Anchorage Project Access referral(s) per year.

_____ Please contact me. I have additional questions regarding my role in Anchorage Project Access.

Print Provider Name

Provider Signature

Date

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AnchorageProjectAccess.org

Internal Use Only
___ Licensed Verified # _____
___ Cares-Provider
___ Cares- Group
___ Added Provider List
___ Ltr Sent
___ Scanned