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: _____

HOW DID YOU HEAR ABOUT US: ☐ TV ☐ Radio ☐ Provider ☐ Patient ☐ Meeting, please list _____
☐ Other _____

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.

_____ _____
Provider Signature Date

Internal Use Only
__ Licensed Verified #_____
__ Cares-Provider
__ Cares- Group
__ Added Provider List
__Ltr Sent
__Scanned

2401 East 42nd Ave Ste 104 ● Anchorage, AK 99508
Phone: (907) 743-6600 ● Fax: (907) 646-0542 ● AnchorageProjectAccess.org