Individual Provider Agreement

Application Reference ID: XXXXXXXXXXXXXX

Date Application Submitted: MM/DD/YYYY

Provider NPI: XXXXXXXXXX

Provider Last Name: XXXXXXXXXXXXXXXXXXXXXXX

Provider First Name: XXXXXXXXXXXXXXXXXXXXXXX

Provider Middle Name: XXXXXXXXXXXXXXXXXXXXXXX

All Exclusion/Sanction Questions and Answers (will be printed here)

Malpractice Coverage Questions and Answers (will be printed here)

I attest that the information submitted on this application is complete and correct and I agree to the terms and conditions as outlined in the DHHS Participation Agreement.

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Signature Date

SAMPLE