THE OHIO STATE UNIVERSITY
HEALTH PLAN

NETWORK REQUEST FORM

Group Name:_____

Tax Id: _____ Group NPI_____

Specialty: _____

Email: _____

Telephone: _____

Website: _____

Practice location(s). What is the service area? Counties served?

_____

_____

Any additional information you would like to include relative to your practice:

_____

_____

_____

_____

_____

_____

Is this a referral from an OSU Health Plan In-Network Provider? Yes

Name of OSU Health Plan provider requesting network inclusion: _____

Contact Information for Person Completing Form

Name_____

Phone Number & Email_____

If you have questions regarding completion of this form, contact Provider Relations at OSUHealthplanPR@osumc.edu.

Please email the completed form to OSUHealthplanPR@osumc.edu or fax to (614) 292-1166.

***Please note that completion of the above information is not confirmation of your participation status with OSU Health Plan. Final contractual status is based upon your ability to meet credentialing standards and any additional contractual obligations.

Determination (INTERNAL USE ONLY):

_____

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