Oklahoma Health Network
Provider Application

Provider Name: ____
Last First Middle

Professional Degree: ____

Primary Specialty: ______________________ ______________________
Subspecialty

Secondary Specialty: ______________________ ______________________
Subspecialty

OK License No._______________ **Tax ID No.**________________ **Medicare No.**_________________

Office Address: ____
Street Address Suite Number

____
City State Zip Code

(___)______________________(___)______________________________
Phone Number Fax Number E-mail Address

Billing Address: ____
(if different) Street Address/P.O. Box Bldg/ Suite / P.O. Box

____
City State Zip Code

(___)______________________(___)______________________________
Phone Number Fax Number E-mail Address

Mailing Address: ____
(if different) Street Address Bldg/ Suite / P.O. Box

____
City State Zip Code

Office Manager: ________________________**Clinic/Group Name:** __________________________

Please list all facilities where you have admitting privileges:

______________________________ ______________________________
Primary Facility Secondary Facility

______________________________ ______________________________
(Other) (Other)

Do you admit patients through a hospitalist ? **Yes**____ **No**____
If yes, please provide the following information
Hospitalist Name (Primary): ____________________________ Hospital:_________________________
Hospitalist Name (Secondary): ____________________________ Hospital:_________________________

Do you have ownership in a facility to which you refer patients? **Yes**____ **No**____
If yes, please list facilities ____

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