

Allina Contact Center - Provider Referral Participation Form

*Fax this page to Medformation at 612-262-4133
or send via e-mail to medicalexchange@allina.com*

Provider Name: _____
Social Security #: _____ **UPIN:** _____ **Date of Birth:** _____
Year Entered Practice: _____ **Male** **Female**
Languages spoken other than English: _____

	Title of Specialty	Board Certified			Date of Certification (cert)
Specialty #1		Yes <input type="checkbox"/>	Eligible <input type="checkbox"/>	No <input type="checkbox"/>	
Specialty #2		Yes <input type="checkbox"/>	Eligible <input type="checkbox"/>	No <input type="checkbox"/>	
	Title of Sub-Specialty	Board Certified			Date of Cert
Sub-Specialty #1		Yes <input type="checkbox"/>	Eligible <input type="checkbox"/>	No <input type="checkbox"/>	
Sub-Specialty #2		Yes <input type="checkbox"/>	Eligible <input type="checkbox"/>	No <input type="checkbox"/>	

Special Procedures: _____

Primary Clinic/Group Name: _____
Primary Clinic Address: _____
City: _____ **State:** _____ **Zip:** _____
Telephone Number: _____ **Fax Number:** _____

(Please provide additional clinics on page 2 of form)

Initial here if you are currently not accepting new patients
 Please notify us when you would like to begin receiving patient referrals

Do you take call for your clinic? Yes No

- () When I'm on call, hospitals may call me directly at home.
- () When I'm on call, providers may call me directly at home.
- () NEVER refer my home telephone.

Pager #: _____ **Home Telephone #:** _____ **Cell phone #:** _____

Education:

Institution	City/State	Year Graduated	Program (G, M, I, R, F)**

****Program Key: G=Graduate School, M=Medical School, I=Internship, R=Residency, F=Fellowship**

Allina Hospital Affiliations <i>(Please check all that apply)</i>			Other Allina Facilities
<input type="checkbox"/> Abbott Northwestern	<input type="checkbox"/> New Ulm Medical Center	<input type="checkbox"/> St. Francis Regional	<input type="checkbox"/> Allina Medical Clinic (AMC) <input type="checkbox"/> Abbott Northwestern Hospital Specialty Care Center – St. Cloud
<input type="checkbox"/> Buffalo	<input type="checkbox"/> Owatonna	<input type="checkbox"/> United	
<input type="checkbox"/> Cambridge Medical Center	<input type="checkbox"/> Phillips Eye Institute	<input type="checkbox"/> Unity	
<input type="checkbox"/> Mercy	<input type="checkbox"/> River Falls Area		

Additional Clinic Sites (If applicable)

Secondary Clinic Information	
Clinic/Group Name:	
Primary Clinic Address: (including city, state, zip)	
Telephone Number:	
Fax Number:	

Third Clinic Information	
Clinic/Group Name:	
Primary Clinic Address: (including city, state, zip)	
Telephone Number:	
Fax Number:	

Fourth Clinic Information	
Clinic/Group Name:	
Primary Clinic Address: (including city, state, zip)	
Telephone Number:	
Fax Number:	

(Please attach additional site information on separate sheet)