

The HomeCare & Hospice Provider Link Enrollment Form

The purpose of this form is to collect the information required to setup your practice on the HomeCare & Hospice Provider Link system.
Please enter all required information to help ensure proper setup. Once complete, please email (preferred) or Fax the completed form to the locations listed below.

Physician Practice Name or Facility: _____ **Phone:** _____

Address: _____

Name (Please Print)	Email Address (Required)**	Physician	PA	CRNP	Nurse Admin	Nurse	Resident	Billing Admin	Billing	Office Staff

I confirm by signing below, that the people indicated above should have the right to access this secured site with the role requested for the patients assigned to me.

Physician Signature: _____ Print Name: _____ Date: _____

Once complete, please email or fax the completed form to:
Email: THCNBusinessSolutions@mlhs.org | Fax: 484.580.1436