truehealth new mexico

Letter of Interest – Individual or Group

Business Name (on your W-9 Form): _____

Practice Name (doing business as/dba): _____

Federal Tax ID#: _____ (**please attach a copy of your W-9 form**)

1. If you are a sole proprietor, what is your Individual NPI? _____

2. If you are a Group Practice, what is your Organizational NPI? _____

3. Practice Specialty: _____

4. If you are a Behavioral Health Provider, what is your licensure? _____

5. Addresses (please attach list if more than one office location):
   Physical: _____
   Billing: _____
   Mailing: _____

6. Scheduling Phone: _____ Referral Fax: _____

7. Billing Phone: _____ Fax: _____
   Billing Contact Person & Title: _____
   Billing Contact Email: _____

8. Primary Practice Contact Person & Title: _____

9. Primary Practice Email: _____

10. Electronic Claims Filing Capability?* ☐ Yes ☐ No
    *Network providers are required by contract to submit electronic claims to True Health New Mexico.

11. Please indicate the email address for delivery of your **final executed contract**:
    _____

Please return form via fax to 1-888-282-3483 or via email to provider.services@truehealthnewmexico.com.

2440 Louisiana Blvd. NE, Suite 601 | ph. 505.633.8020
Albuquerque, New Mexico 87110 | web. truehealthnewmexico.com