Horizon NJ Health

Network Operations

Provider Application Request Form

Date: _____

Provider Name: _____

Specialty: _____

Group Name: _____
(If applicable)

Tax Identification Number (TIN): _____

National Provider Identifier (NPI): _____

Provider Address: _____

_____

Telephone Number: _____

County: _____

Hospital Affiliations: _____

Ambulatory Surgi-Center Affiliations: _____

Are you participating with Horizon HMO? Yes ❑ No ❑

Contact Person/Office Manager: _____

Are there other providers practicing at your location? Yes ❑ No ❑
If yes, please include their names and specialty below:

Provider Name	Specialty

Please fax or mail to:

Horizon NJ Health
Attention: Professional Relations Department
210 Silvia Street
West Trenton, NJ 08628
Telephone: 800-682-9094 Fax: 609-583-3004