Transforming Lives

Trillium HEALTH RESOURCES

# Network Application Request

Please complete all fields in this form before submitting.

## Provider Information

Name: _____

Corporate Address: _____

Site Address: _____

Phone Number: _____

Contact Person: _____

Contact Person's Email: _____

Tax ID #: _____

NPI #: _____

Taxonomy: _____

Current Trillium Contractual Relationship:

☐ Full Contract ☐ Existing CSA ☐ No current agreement in place

Provider Entity Type:

☐ Agency ☐ Group ☐ LIP ☐ Hospital

Funding Source:

☐ State Funded ☐ Medicaid ☐ Innovation Waiver ☐ B3

| Service(s) requested: | Service Code(s): |
|---|---|
| | |

Effective Date to be implemented: _____

Expedited? ☐ Yes ☐ No

If yes, please select appropriate criteria:

☐ Residential
☐ Hospital Discharge
☐ Medication Issue
☐ Health & Safety Concern

## Individual Information

Name: _____

Date of Birth: _____

Current Physical Address: _____

## Reason for Request

Please select applicable option:

- ☐ Site Addition
- ☐ Service Addition
- ☐ New Contract
- ☐ Modification to Existing CSA
- ☐ New CSA
- ☐ Other: _____

Name of Trillium Staff Submitting Request: _____

## Network Decision

Check which applies: ☐ Approved ☐ Not Approved

_____ _____

Signature Date