



LETTER OF INTENT

FOR PARTICIPATION IN THE BEHAVIORAL HEALTH NETWORK

Instructions: Please complete one copy of this letter and Form W-9 for each provider interested in joining the network. Fax this letter, Form W-9, and a copy of each provider's State license and Insurance Certificate to: (813) 262-2982 or mail to: Harmony Behavioral Health, Attn: Provider Relations, P.O. Box 31402, Tampa, FL 33631-3402.

LICENSE TYPE

- Psychiatrist (MD or DO)
 Advanced Registered Nurse Practitioner (ARNP)
 Physician Assistant (PA)
 Clinical Psychologist (PsyD or PhD)
 Licensed Clinical Social Worker (LCSW)
 Licensed Mental Health Counselor (LMHC)
 Licensed Marriage & Family Therapist (LMFT)

APPLICATION TYPE

- Individual Practice/Clinic
 Group Practice/Clinic
 Community Mental Health Center
 Hospital
 Residential Treatment Facility
 Other: (specify) _____

PROVIDER INFORMATION

Provider Last Name	First Name
Tax ID Number	Florida License Number
Street Address	
City, State, Zip Code	Email Address
Telephone Number	Fax Number

BEHAVIORAL HEALTH SERVICES OFFERED

	Age Groups	Hours of Operation
<input type="checkbox"/> Medicare <input type="checkbox"/> Mental Health <input type="checkbox"/> Substance Abuse	<input type="checkbox"/> 00-20 <input type="checkbox"/> 21-99 <input type="checkbox"/> All Ages	Mon Tues Wed Thurs Fri Sat From: _____ To: _____
<input type="checkbox"/> Medicaid <input type="checkbox"/> Mental Health <input type="checkbox"/> Substance Abuse	<input type="checkbox"/> 00-05 <input type="checkbox"/> 06-17 <input type="checkbox"/> 18-99 <input type="checkbox"/> All Ages	Mon Tues Wed Thurs Fri Sat From: _____ To: _____
<input type="checkbox"/> Healthy Kids <input type="checkbox"/> Mental Health <input type="checkbox"/> Substance Abuse	<input type="checkbox"/> 00-19	Mon Tues Wed Thurs Fri Sat From: _____ To: _____

The undersigned desires to become a participating behavioral health provider and understands that until a provider agreement is executed by both parties and an effective date is established, the provider is considered a "non-participating provider" and payment for authorized, covered services rendered to eligible health plan members is limited to the applicable prevailing reimbursement rate(s).

Provider Signature

Date

Provider Name