

# Physician Enrollment Form



Choose one of the following:

- New enrollment (please complete entire form)
- Change to previous enrollment (complete applicable areas, name, DEA #, sign and date)
- Cancellation of enrollment (name, DEA #, sign and date.) We will call you to confirm

Note: Please type or print clearly.

Please fax forms to **1-800-239-0976**

1 form  2 forms

\* Denotes required information

Physician Name\*: \_\_\_\_\_ XDEA #\*: \_\_\_\_\_

**Here to Help Participation Levels (choose only one)**

- Level 1:** I will receive referrals via Care Coordinators **and** have my office information available on the Here to Help™ website.
- Level 2:** I will receive referrals via Care Coordinators. **Do not** make my information public on the Here to Help website.
- Level 3:** I will refer my patients to Here to Help Care Coaching. **Do not** make my information public. **Do not** refer patients to me at this time.  
I will notify Here to Help if my availability to accept new patients changes.

Information on Treatment Site 1	Information on Treatment Site 2
Clinic name: _____	Clinic name: _____
Address: _____	Address: _____
City: _____ State: _____ <b>ZIP*</b> : _____	City: _____ State: _____ <b>ZIP*</b> : _____
Phone number: (     ) _____ - _____ Ext: _____	Phone number: (     ) _____ - _____ Ext: _____
Fax number: (     ) _____ - _____	Fax number: (     ) _____ - _____
Contact e-mail (for Here to Help contact only): _____	Contact e-mail (for Here to Help contact only): _____

Scheduling Information at Treatment Site 1	Scheduling Information at Treatment Site 2
Direct Scheduling Line to be used when a Care Coordinator transfers a patient seeking treatment: (     ) _____ - _____ Scheduling hours: _____	Direct Scheduling Line to be used when a Care Coordinator transfers a patient seeking treatment: (     ) _____ - _____ Scheduling hours: _____
<input type="checkbox"/> Do not give this number to patients	<input type="checkbox"/> Do not give this number to patients
<input type="checkbox"/> Do not leave messages at this number	<input type="checkbox"/> Do not leave messages at this number

Insurance Accepted at Treatment Site 1	Insurance Accepted at Treatment Site 2
<input type="checkbox"/> Humana <input type="checkbox"/> Cigna <input type="checkbox"/> Aetna <input type="checkbox"/> United Healthcare <input type="checkbox"/> BlueCross/BlueShield <input type="checkbox"/> Medicaid <input type="checkbox"/> None/cash only <input type="checkbox"/> No Medicaid accepted	<input type="checkbox"/> Humana <input type="checkbox"/> Cigna <input type="checkbox"/> Aetna <input type="checkbox"/> United Healthcare <input type="checkbox"/> BlueCross/BlueShield <input type="checkbox"/> Medicaid <input type="checkbox"/> None/cash only <input type="checkbox"/> No Medicaid accepted
Other Insurance Plans Accepted: _____	Other Insurance Plans Accepted: _____

**Agreement**

<p>I agree to have the Here to Help Program connect patients (Levels 1 and 2) seeking treatment with my office(s) and will make my best effort to see those patients within 7 business days of first contact.</p> <p>I agree to contact Here to Help if I am no longer accepting new patients at <b>866-972-HERE (4373)</b>.</p> <p>I agree to have patients (Levels 1 and 2) transferred to my appointment desk in order to make their first appointments.</p> <p>I agree that Reckitt Benckiser Pharmaceuticals Inc. is not responsible for my abiding by local, state, and federal laws pertaining to my practice.</p>	<p>I understand that this enrollment does not affect the way I am listed on the CSAT physician locator. The CSAT physician locator is a government supported website and all communication regarding the contents must be given to CSAT at <b>240-276-2750</b>. You can find information at <a href="http://csat.samhsa.gov">csat.samhsa.gov</a>.</p> <p>I agree that Reckitt Benckiser Pharmaceuticals Inc. is not responsible for my treatment outcomes.</p>
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**Signature\*** \_\_\_\_\_ **Date\*** \_\_\_\_\_