Provider Participation Request Form

SANFORD HEALTH PLAN

Members are to use this form when you would like to have Sanford Health Plan's Provider Contracting team contact a non-participating provider for inclusion in Sanford Health Plan's broad network. This document is not an application, but a request for in-network participation. Although we cannot guarantee participation with the provider, we will review your request. We encourage you to follow up with the provider as well.

Complete this form and submit by:
Fax: (605) 328-7224 attention Provider Contracting; or
Scan & email: SanfordHealthPlanProviderContracting@sanfordhealth.org

Member Information *(please print)*:

Name (First & Last) | Member ID# | Date of Birth

Address (including City, State & Zip)

Phone | Email | Date Submitted

Provider Information *(please print)*:

Name (First & Last) | Degree/License (e.g. M.D., P.A., and L.P.C.)

Specialty

Clinic/Facility Name | Phone

Clinic/Facility Address (including City, State & Zip)