



PROVIDER NETWORK PARTICIPATION REQUEST FORM

Facility Information (One Form must be submitted for each location/address)

DBA/Facility Name: _____ Tax ID # _____

Address: _____

City _____ County _____ State _____ Zip _____

Phone # _____ Fax# _____ Administrator / Contact Name _____

Mailing/Correspondence Address: _____ (Same as above)

City _____ County _____ State _____ Zip _____

Phone #: _____ Fax #: _____ Contact Name _____

Is this a Multi-Specialty Provider Group? [] Yes [] NO

Years in Business: _____ Number of Office Locations: _____ Languages Spoken: _____

Does your facility provide any Specialty Services or care in the following Specialty Areas?

(Please check all boxes which apply)

<input type="checkbox"/> Amputee Rehab	<input type="checkbox"/> Pediatric Physical Therapy (0 to 3 yrs)
<input type="checkbox"/> Aquatic Therapy	<input type="checkbox"/> Pediatric PT Developmental Delay (0 to 3 yrs)
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Pediatric PT Non-Developmental Delay (0 to 3 yrs)
<input type="checkbox"/> Back School	<input type="checkbox"/> Pediatric Physical Therapy (4 years and up)
<input type="checkbox"/> Balance Therapy	<input type="checkbox"/> Pediatric PT Developmental Delay (4+ yrs)
<input type="checkbox"/> Brain Injury Rehabilitation	<input type="checkbox"/> Pediatric PT Non-Developmental Delay (4+ yrs)
<input type="checkbox"/> Burn – 2nd and/or 3rd Degree	<input type="checkbox"/> Pediatric Occupational Therapy (0 to 3 yrs)
<input type="checkbox"/> Cardiac Rehabilitation	<input type="checkbox"/> Pediatric OT Developmental Delay (0 to 3 yrs)
<input type="checkbox"/> Cardiopulmonary Rehabilitation	<input type="checkbox"/> Pediatric OT Non-Developmental Delay (0 to 3 yrs)
<input type="checkbox"/> Certified Hand Therapist - PT	<input type="checkbox"/> Pediatric Occupational Therapy (4 years and up)
<input type="checkbox"/> Certified Hand Therapist - OT	<input type="checkbox"/> Pediatric OT Developmental Delay (4+ yrs)
<input type="checkbox"/> Clinical Electrophysiology	<input type="checkbox"/> Pediatric OT Non-Developmental Delay (4+ yrs)
<input type="checkbox"/> Cognitive Training – OT	<input type="checkbox"/> Pediatric Sensory Integration Therapy/Training
<input type="checkbox"/> CVA Rehabilitation	<input type="checkbox"/> Physical Therapy
<input type="checkbox"/> Functional Capacity Evaluation	<input type="checkbox"/> Pre-Op Program
<input type="checkbox"/> Geriatrics	<input type="checkbox"/> Speech Language Pathology (Speech Therapy)
<input type="checkbox"/> Hand Splinting	<input type="checkbox"/> Spinal Cord Injury Rehabilitation- PT
<input type="checkbox"/> Hydro-Therapy	<input type="checkbox"/> Spinal Cord Injury Rehabilitation- OT
<input type="checkbox"/> Lymphedema – Manual Lymphatic Drainage (MLD Certified?) ___ YES ___ NO	<input type="checkbox"/> Spinal Disorders
<input type="checkbox"/> Mobilization – Soft Tissue	<input type="checkbox"/> Sports Physical Therapy
<input type="checkbox"/> Myofascial Release	<input type="checkbox"/> TMJ Disorders
<input type="checkbox"/> Neurologic Care- Physical Therapy	<input type="checkbox"/> Upper Extremity Schools
<input type="checkbox"/> Neurologic Care- Occupational Physical Therapy	<input type="checkbox"/> Urinary Incontinence
<input type="checkbox"/> Neurologic Care- Speech Therapy	<input type="checkbox"/> Urinary Stress Incont. Biofeedback
<input type="checkbox"/> Occupational Therapy	<input type="checkbox"/> Vestibular Rehabilitation
<input type="checkbox"/> Oncology	<input type="checkbox"/> Work Hardening / Industrial Rehabilitation
<input type="checkbox"/> Orthopedic Care	<input type="checkbox"/> Work Simulation
<input type="checkbox"/> Orthotics	<input type="checkbox"/> Wound Care
	<input type="checkbox"/> Other Specialty Services: _____

Comments: _____

Mail or fax completed form to: **OrthoNet**
Attn: **Provider Contracting**
1311 Mamaroneck Avenue
White Plains, NY 10605
Fax: 888-692-1117 Phone: 888-257-4353
Please allow 2-3 weeks for processing