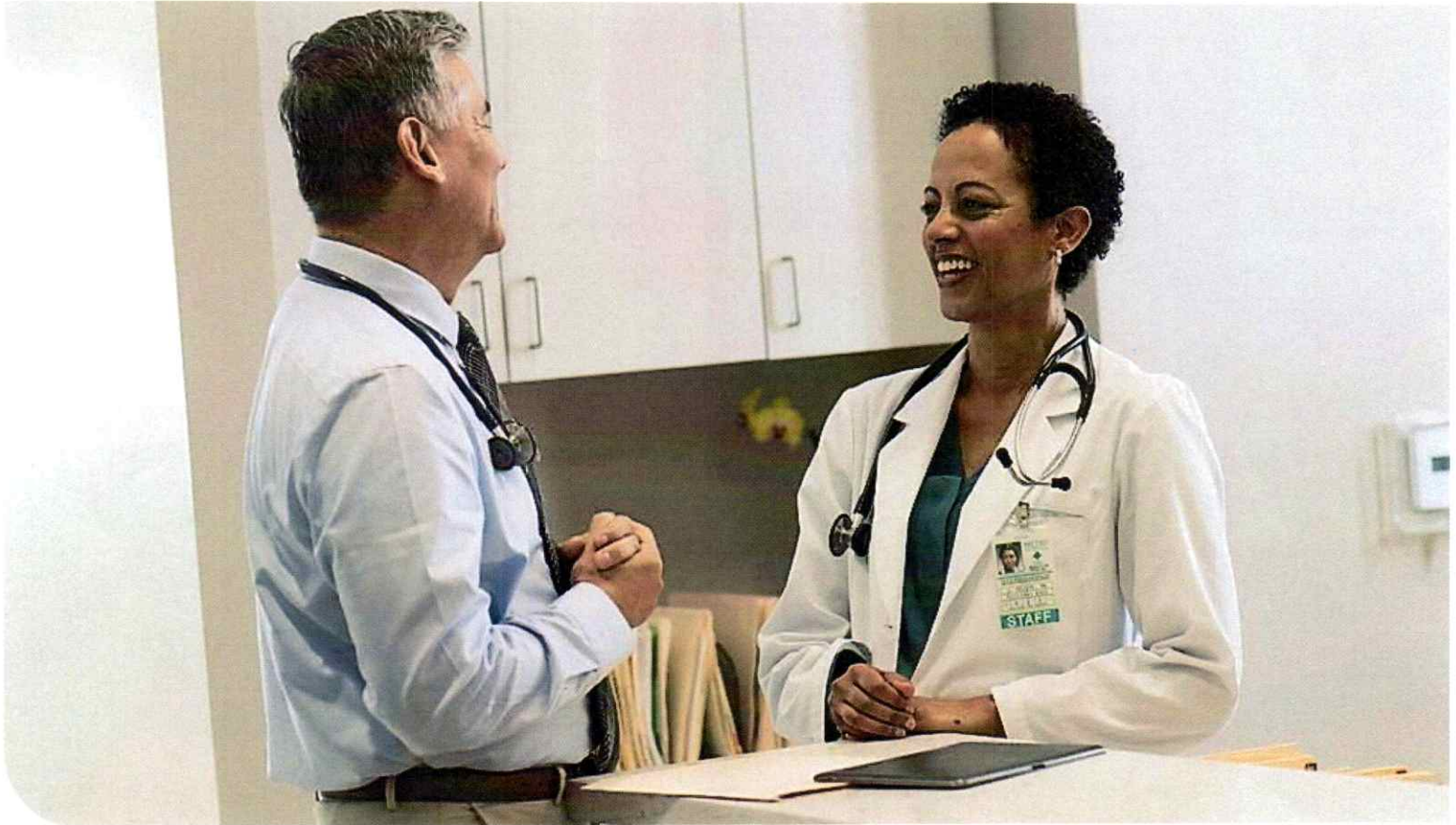


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## Join our network

Thank you for your interest in Humana.

Many physicians and other healthcare providers may request to join the Humana and ChoiceCare® networks by completing an online form. Others need to follow a different process. Please review the information below for details.

[Join our network](#)

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The online contracting tool is not available in the following states:

- Florida (North/Central)
- Kentucky
- Maine
- New Hampshire
- New York
- Puerto Rico

Please [review this document](#) to determine whom you should contact in these markets.

## Limitations for online contracting

The markets listed below are accepting limited types of applications:

- Alabama
- Arizona
- California
- Colorado
- Hawaii
- Florida (South Florida/Primary Care Physicians – commercial only)
- Mississippi
- Nevada

**Join our network**

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If you are in one of these markets, please review the before applying.

[Contracting information for specific markets](#)

## Apply to Humana's medical network

If you are eligible to use our online application, follow the directions below:

### Step 1: Review this important information

[Key information about contracting with Humana](#)

Step 2: Go to the following page and fill out the form.

[Humana medical provider network online application](#)

## Apply to Humana's dental network

[Humana Dental application](#)

[Learn more about joining Humana's network as a dental provider](#)

## Apply to Humana's vision network

Vision providers can apply to the Humana Vision Insight network through the website of our partner, EyeMed®. Visit [EyeMed's website](#) and select the "Complete our online interest form" button.

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Humana actively recruits:

- Psychiatrists
- Nurse practitioners certified in behavioral health or psychiatry
- Psychologists
- Social workers
- Licensed professional counselors
- Licensed marriage and family therapists
- Behavioral health professionals who are licensed independently in the state where they practice.

We also are seeking individuals who hold a Certified Employee Assistance Professional (CEAP) certification in conjunction with the required state license.

If you would like to join Humana's behavioral health network, please email us at [BehavioralHealthProviderServices@humana.com](mailto:BehavioralHealthProviderServices@humana.com).

## Frequently asked questions for medical providers

### **Q: What happens after I successfully submit my contract request online?**

**A:** Humana contracting representatives will review your request and may contact you for additional or clarifying information. When all necessary information has been received, a Humana representative will contact you to initiate a participation agreement. You'll have an opportunity to review the agreement and be asked to sign it and return it to Humana. Credentialing may be required before an agreement becomes effective, and you may be asked for additional information to complete credentialing. Once credentialing is complete, you'll receive a copy of the contract. It will be signed by a Humana representative, and you will be advised of your effective date with Humana.

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**A:** If your request was submitted within the past 90 days, please call Humana Provider Relations at 800-626-2741 (TTY: 711), Monday – Friday, 8 a.m. – 5 p.m., Central time. If more than 90 days have passed since you submitted your request, please resubmit your request using our online application process, unless you are in a state where the online application process is not available. If you submitted a request directly to a Humana market office, please follow up with that office.

**Q: My contract request was not accepted. Can I reapply in the future?**

**A:** Yes.

**Q: How can I find out why my contract request was not accepted?**

**A:** Please call Humana Provider Relations at 800-626-2741 (TTY: 711), Monday – Friday, 8 a.m. – 5 p.m., Central time.

**Q: Will I need to submit documentation when completing the web form?**

**A:** No, you will not be asked to upload documentation. You will, however, need to have several pieces of information handy. Please review the instructions on this page for a list of the types of information you will need when completing the web form.



**Need help?**

Please call Humana Provider Relations at

**800-626-2741 (TTY:711)**

between 8 a.m. and 5 p.m. Central time, Monday through Friday.

**Join our network**

For questions regarding credentialing status, please contact our credentialing department at [dentalcredentialing@humana.com](mailto:dentalcredentialing@humana.com).

If you have a questions about a contract, fee schedule or other service issues, please contact [dentalservice@humana.com](mailto:dentalservice@humana.com).

Are you a behavioral health professional?

If you have a questions about a contract, fee schedule or other service issues, please contact [behavioralhealthproviderservices@humana.com](mailto:behavioralhealthproviderservices@humana.com).



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 **Humana legal entities that offer, underwrite, administer or insure insurance products**

Join our network

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# Apply to our network

How will you file your claims to Humana? \*

- I will file my claims to Humana using my Social Security Number (SSN).
- I will file my claims to Humana using an Employer Identification Number (EIN) or Taxpayer Identification Number (TIN).

Please enter this information exactly as it appears on your federal income tax return.

\* Required fields

## 1. Business information

**EIN/TIN:** the Employer Identification Number and Taxpayer Identification Number are used to identify business entities for tax and identification purposes.

EIN/TIN \*

Business type \*

**DBA name:** a trade name or “doing business as” name is the name you choose for your business that is different from your personal name, the names of your partners or the officially registered name of your

company.

Legal business name \*

DBA name

## Exempt payee

Select your exempt payee code and/or Foreign Account Tax Compliance Act (FATCA) exemption code. For more information, view [W-9 certification instructions](#)

**Exempt payee:** an individual or group that receives income for which backup withholding is not required. Anyone who is tax exempt must complete a W-9 form.

**Exempt payee code:** the codes on a W-9 form that identify types of payees who are exempt from backup withholding.

**FATCA exemption code:** the codes on a W-9 form identifying payees who maintain financial assets outside of the United States but are exempt from reporting those assets.

Exempt payee code

and / or

FATCA exemption code

Business address

Street address \*

Street address 2

City \*

State \*

ZIP code \*

County \*

## National Provider Identification Number

Enter the billing **National Provider Identification Number (NPI)** associated with your SSN. The NPI is a unique identifier for covered healthcare providers adopted as part of the Health Insurance Portability and Accountability Act.

The NPI is a unique identifier for covered health care providers adopted as part of the Health Insurance Portability and Accountability Act.

Billing NPI \*

## W-9 certification

For more information, [view W-9 certification instructions](#)

By entering my name below, under penalty of perjury, I certify the following

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me).

2. Am I subject to backup withholding? \*

Yes

No

I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding.

3. I am a U.S. citizen or other U.S. person.

4. The FATCA code entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Please enter your name to certify the above.

First name \*

MI

Last name \*

## 2. Primary contact information

Humana may need to contact you regarding your application for a network participation agreement. Please enter the following information for the person who has the responsibility for contract-related issues.

First name \*

Last name \*

Phone number \*

Fax number \*

Email \*

Contact Address \*

- Use business address
- Add new contact address

By clicking "Next," I agree that the above information is correct, and I understand and agree to the Humana Privacy Policy.

Next

Cancel



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