HEALTH*FIRST* INC. ENROLLMENT FORM

ENROLLMENT FORM DIRECTIONS

1. Please type your information into the Enrollment Form.

2. Save the .pdf document to your computer.

3. Then email it to **Health***first* as an attachment to:

member@vthealth1st.org

HEALTH*FIRST* INC. ENROLLMENT FORM

PRACTICE/GROUP INFORMATION

Region (please check one):

Region 1:	Bennington ☐	Rutland ☐	Windham ☐	Windsor ☐		
Region 2:	Addison ☐	Caledonia ☐	Orange ☐	Washington ☐		
Region 3:	Chittenden ☐	Essex ☐	Franklin ☐	Grand Isle ☐	Lamoille ☐	Orleans ☐

PLEASE PRINT CLEARLY

Practice Name:		
Practice address (if multiple, please use additional sheet of paper for all practice locations):		
City:	State:	ZIP Code:
Mailing address (if different):		
City:	State:	ZIP Code:
Billing address (if different):		
City:	State:	ZIP Code:
Tax ID:	Group NPI (if applicable):	

CONTACT INFORMATION

Administrative Contact (i.e. office manager) Name:	
Telephone:	Email:
Physician Contact Name:	
Telephone:	Email:

MISCELLANEOUS:

Do you currently participate in Group Purchasing?: Yes ☐ No ☐	Do you belong to another PHO, IPA, PO: Yes ☐ No ☐

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INDIVIDUAL PRACTITIONER INFORMATION

Please list each practitioner separately (use additional sheet of paper if more space is needed):

Name:	**NPI:**

SPECIALTY (PLEASE LIST ALL)

Please check one: Primary Care (Internal Medicine, Family Medicine or Pediatrics) ☐ Specialist ☐

Practicing/Primary Specialty:	Email:

Additional Specialties(indicate other Board Certification in addition to above):

EMPLOYMENT STATUS

Self employed ☐	Employed: ☐ Employer Name:

HOSPTIAL AFFILIATIONS (PLEASE LIST ALL)

Hospital 1:	Hospital 2:

Primary Care Only: Are you currently participating in the Blue Print/Medical Home? Yes ☐ No ☐

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INDIVIDUAL PRACTITIONER INFORMATION	
Please list each practitioner separately (use additional sheet of paper if more space is needed):	
Name:	**NPI:**
SPECIALTY (PLEASE LIST ALL)	
Please check one: Primary Care (Internal Medicine, Family Medicine or Pediatrics) ☐ Specialist ☐	
Practicing/Primary Specialty:	Email:
Additional Specialties(indicate other Board Certification in addition to above):	
EMPLOYMENT STATUS	
Self employed ☐	Employed: ☐ Employer Name:
HOSPTIAL AFFILIATIONS (PLEASE LIST ALL)	
Hospital 1:	Hospital 2:
Primary Care Only: Are you currently participating in the Blue Print/Medical Home? Yes ☐ No ☐	

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INDIVIDUAL PRACTITIONER INFORMATION	
Please list each practitioner separately (use additional sheet of paper if more space is needed):	
Name:	**NPI:**
SPECIALTY (PLEASE LIST ALL)	
Please check one: Primary Care (Internal Medicine, Family Medicine or Pediatrics) ☐ Specialist ☐	
Practicing/Primary Specialty:	Email:
Additional Specialties(indicate other Board Certification in addition to above):	
EMPLOYMENT STATUS	
Self employed ☐	Employed: ☐ Employer Name:
HOSPTIAL AFFILIATIONS (PLEASE LIST ALL)	
Hospital 1:	Hospital 2:
Primary Care Only: Are you currently participating in the Blue Print/Medical Home? Yes ☐ No ☐	

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INDIVIDUAL PRACTITIONER INFORMATION	
Please list each practitioner separately (use additional sheet of paper if more space is needed):	
Name:	**NPI:**
SPECIALTY (PLEASE LIST ALL)	
Please check one: Primary Care (Internal Medicine, Family Medicine or Pediatrics) ☐ Specialist ☐	
Practicing/Primary Specialty:	Email:
Additional Specialties (indicate other Board Certification in addition to above):	
EMPLOYMENT STATUS	
Self employed ☐	Employed: ☐ Employer Name:
HOSPTIAL AFFILIATIONS (PLEASE LIST ALL)	
Hospital 1:	Hospital 2:
Primary Care Only: Are you currently participating in the Blue Print/Medical Home? Yes ☐ No ☐	

Please fax the completed form to 802-878-8816 or email to member@vthealth1st.org
THANK YOU!