HomeCare & Hospice
Main Line Health®

# *The HomeCare & Hospice Provider Link Enrollment Form*

**The purpose of this form is to collect the information required to setup your practice on the HomeCare & Hospice Provider Link system.**
**Please enter all required information to help ensure proper setup. Once complete, please email (preferred) or Fax the completed form to the locations listed below.**

**Physician Practice Name or Facility:** ______________________________________________ **Phone:** ____________________

**Address:** ____________________________________________________________________________________________

| Name (Please Print) | Email Address (Required)** | Physician | PA | CRNP | Nurse Admin | Nurse | Resident | Billing Admin | Billing | Office Staff |
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I confirm by signing below, that the people indicated above should have the right to access this secured site with the role requested for the patients assigned to me.

Physician Signature: ___________________________ Print Name: ______________________________ Date: __________________

**Once complete, please email or fax the completed form to:**
**Email: THCNBusinessSolutions@mlhs.org | Fax: 484.580.1436**