OSF Direct Access Network (DAN)
Provider Request for Participation

Applicant Name: _____
First Middle Last Title

Legal Business Name:_____
Physical Address:_____
_____
City County State Zip

***** YOU MUST SUBMIT A COPY OF CURRENT W-9 WITH THIS FORM*****

Specialty: _____ Phone: _____ Fax: _____

If a Physician (M.D./D.O.), are you board certified through an ABMS or AOA Board?..... Yes ☐ No ☐
If not board certified, when were you eligible?..... _____
If a Podiatrist, are you board certified through ABPS or other source?..... Yes ☐ No ☐
If not, when were you eligible?..... _____
If a DME provider, are you licensed in Illinois?..... Yes ☐ No ☐
If a Doctor of Optometry, are you TPA & DPA Certified?.. Yes ☐ No ☐
If a Facility provider, are you JCAHO Accredited?..... Yes ☐ No ☐
Do you have at least $1million ea. occ./$3million agg. of Professional Liability coverage?..... Yes ☐ No ☐

Hospital Privileges	Hospital	Status
	_____	_____
	_____	_____

Ownership:

_____ ☐ Physician Owned ☐ Hospital Owned
_____ ☐ Owned Component of Integrated Health System
☐ Other (explain)

_____ _____ _____
Person Completing Form Title Phone/Email

Please send completed form to: Fax: 309-308-5095 or Mail: 7707 N. Knoxville Ave., Ste. 200, Peoria, IL 61614