Provider Network Expansion Fund Program Application

Please refer to the **Network Expansion Fund Program Description** on the IEHP website for information regarding the program. To apply for funding complete the application below, for any questions or to submit your application please contact the:

Provider Network Analyst's Team at NEFProgram@iehp.org

EMPLOYING/CONTRACTING ENTITY INFORMATION	
Entity Name: _____	Contact Person: _____
Entity Address: _____	Contact Phone #: _____
Entity City & Zip: _____	Contact Email: _____
Entity TIN: _____	**HOW DID YOU HEAR ABOUT THE PROGRAM?**
Contracted with IEHP: ◯ **Yes** ◯ **No**	Select Reason from Dropdown List

POSITIONS TO BE FUNDED

Have you identified a candidate? ◯ **Yes** ◯ **No** *If yes, please write their name(s) below and attach a CV. We will NOT accept an application without a CV.*

APP, PCP, or SPEC	NPI	Specialty	Name	Practice Address

FUNDING JUSTIFICATION

Please attach a detailed letter providing specific information and data to justify why these positions should be funded, including but not limited to case load of current providers at practice, work schedule/office hours, access times for appointments, etc.