Out of Network Provider Request Form

Submit completed form and current copy of W9. Incomplete submissions will delay access the McLaren Health Plan Portal or claims payment.

- Email: MHPProviderServices@mclaren.org
- Fax: (810) 600-7979

Submit

Provider Information	
Provider Name and Degree	
Tax ID	
Individual NPI	
Individual Primary Taxonomy	
Individual Additional Taxonomy	
Practice Group/Facility Name	
Type II/Group NPI	
Group/Facility Primary Taxonomy	
Group/Facility Additional Taxonomy	
Phone	
Fax	
Email	
Website address	

Service Address	
Address	
City, State, ZIP Code +4	
Location NPI (if different than NPI listed above)	

Mailing Address	
Address	
City, State, ZIP Code +4	

Billing Address	
Address	
City, State, ZIP Code +4	

Pay To (Remit) Address – *copy of W9 is required*	
Address	
City, State, ZIP Code +4	

Would you like to receive a contract for participation with McLaren Health Plan

Yes ☐ No ☐

Send Contract via mail to:	**Send Contract via email to:**
Address:	Email:

Upon registration into McLaren Health Plan's systems, you will receive a confirmation email that will allow you to register with the McLaren Connect Portal.