Please send completed form to:
CMN Inc.
Attn: Provider Relations
150 Commerce Valley Drive West, 9th Floor
Thornhill, Ontario, Canada L3T 7Z3
Tel: +1-905-669-4333
Fax: +1-905-669-2318

Provider Participation Form

A. DEMOGRAPHIC INFORMATION

Full Name of Physician, Group or Facility			
Physical Address (No., Street)			
City	State/Province	Zip/Postal Code	Country
Telephone (include area code) ( )	Fax (include area code) ( )	Website Address	
Billing/Payment Remit Address			
Billing/Payee Name	Billing/Payment Remit Address (No., Street)		
City	State/Province	Zip/Postal Code	Country
Telephone (include area code) ( )	Fax (include area code) ( )	Website Address	

B. DEPARTMENTAL CONTACT INFORMATION

Scheduling and Admissions	E-mail Address	Telephone (include area code) ( )
Contracting	E-mail Address	Telephone (include area code) ( )
Billing/Patient Accounts (Department Manager)	E-mail Address	Telephone (include area code) ( )

C. ADDITIONAL HOSPITAL INFORMATION - Hospitals Only

Number of general acute care beds	Number of ICU beds	Number of pediatric ICU beds	Number of neonatal ICU beds	Number of inpatient admissions in the last 12 months
Most common surgical procedure performed in the last 12 months			Mortality rate	Complication rate
Is there an International Patient Department within the hospital? ☐ Yes ☐ No		Is the hospital currently a member of a broader hospital group? ☐ Yes ☐ No	If YES, which one?	

D. SPECIALTY INFORMATION - Hospitals and Physicians

How many physicians currently participate in your practice? ________

Please specify the specialty or specialties practiced by your hospitals/physicians

☐ Alternative Medicine	☐ Emergency Medicine	☐ Ophthalmology	☐ Pulmonology
☐ Andrology	☐ Gastroenterology	☐ Orthopedics	☐ Psychiatry
☐ Anesthesiology	☐ General Practice	☐ Otolaryngology (ENT)	☐ Radiology
☐ Cardiology	☐ Internal Medicine	☐ Pathology	☐ Reconstructive/Cosmetic Surgery
☐ Cardiothoracic Surgery	☐ Long Term Care	☐ Physiotherapy	☐ Surgery (please specify type)
☐ Counseling and Social Work	☐ Neonatology	☐ Pediatrics (please specify any sub-specialties)	________________
☐ Dentistry	☐ Neurology	________________	☐ Urology
☐ Dermatology	☐ Obstetrics and Gynecology	☐ Podiatry	☐ Other (please specify)
☐ Durable Medical Equipment	☐ Oncology and Hematology	☐ Proctology	________________

We greatly appreciate your interest in working with CMN.
A Provider Relations representative will contact you after reviewing the completed form.