OSF Direct Access Network (DAN)
Provider Request for Participation

1. Applicant Name: _____
   First Middle Last Title
2. Legal Business Name: _____
3. Physical Address: _____
   _____
   City County State Zip Code
4. Specialty: _____ Phone: _____ Fax: _____
5. Ownership:
   _____ ☐ Physician Owned ☐ Hospital Owned
   _____ ☐ Owned component of an Integrated Health System
   ☐ Other (explain)
6. Group NPI Number: _____
7. Certification / Licensure / Accreditation:
   a. If a Physician (MD/DO), are you board certified through an ABMS or AOA Board? ..... Yes ☐ No ☐
      If not, when were you eligible? ..... _____
   b. If a Podiatrist, are you board certified through ABPS or other source? ..... Yes ☐ No ☐
      If not, when were you eligible? ..... _____
   c. If a DME provider, are you licensed in Illinois? ..... Yes ☐ No ☐
   d. If a Doctor of Optometry, are you TPA & DPA Certified? .... Yes ☐ No ☐
   e. If a facility provider, are you JCAHO Accredited? ..... Yes ☐ No ☐
8. Do you have at least $1 million each occurrence / $3 million aggregate of Professional Liability coverage? ..... Yes ☐ No ☐
9. Hospital Privileges:

Hospital	Status
_____	_____
_____	_____

10. Do you currently practice in the 32-county service area? ..... Yes ☐ No ☐
11. Have you ever participated in the Direct Access Network under a different legal business name? ..... Yes ☐ No ☐
    If yes, please list legal business name. ..... _____

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

12. Have you attached a copy of your W-9? ..... Yes ☐ No ☐

_____ _____ _____
Person Completing Form Title Phone/Email

Please send completed form to 309-517-5440 (fax) or osfdirectaccessnetwork@osfhealthcare.org (email)

March 2024