PRINT CLEAR

For DWC only: MPN Identification Number	Date Application Received:

Cover Page for Medical Provider Network Application or Plan for Reapproval

1. Legal Name of MPN Applicant_____

2. MPN Applicant Address

_____

_____

3. Tax Identification Number __ __ - __ __ __ __ __ __ __

4. Eligibility Status of MPN Applicant

- ☐ Self-Insured Employer (including SISF)
- ☐ Group of Self-Insured Employers
- ☐ Insurer (including CIGA, UEBTF)
- ☐ Joint Powers Authority
- ☐ State
- ☐ Entity that provides physician network services

5. Name of Medical Provider Network_____

6. If the medical provider network is using one of the following deemed entities, check the appropriate box:

- ☐ Health Care Organization (HCO)
- ☐ Health Care Service Plan
- ☐ Group Disability Insurer
- ☐ Taft-Hartley Health and Welfare Trust Fund

7. Is this a plan for reapproval? ☐ Yes ☐ No If Yes, include date of last MPN approval and MPN Identification Number:

_____

8. MPN Website Address:_____

9. MPN Provider Listing Web Address:_____

10. Signature of authorized individual: "I, the undersigned officer or employee of the MPN applicant, have read and signed this application and know the contents thereof, and verify that, to the best of my knowledge and belief, the information included in this application is true and correct."

_____

Name of Authorized Individual Title

_____

Phone Email

_____

Signature of Authorized Individual Date Signed

11. Authorized Liaison to DWC:

Name	Title	Organization
Phone	Email	
Address	Fax number	

Submit two copies of the completed, signed Cover Page for Medical Provider Network Application or Plan for Reapproval and the complete MPN Plan in compact discs or flash drives in word searchable PDF format to the Division of Workers' Compensation. Mailing address: DWC, MPN Application, P.O. Box 71010, Oakland, CA 94142.

[DWC Mandatory Form - Section 9767.4 - [08/14]