True Health New Mexico
Letter of Interest

All Letters of Interest must be submitted with a current and valid W-9(s) for consideration.

- Submit this form for **ALL** new provider groups and individual practitioners interested in joining the True Health New Mexico network.
- Please complete each section of the form that pertains to your specialty. This will help True Health New Mexico determine if your specific qualification align with the service needs of the network.
- Complete all forms and email the packet to contracting@truehealthnewmexico.com.

SECTION 1: SUBMITTER INFORMATION		
Contracting Contact Name:		
Company:		
Business Name:		
Title/Position:		
Email	Telephone:	
SECTION 2: BUSINESS DEMOGRAPHIC INFORMATION		
DBA (as listed on W-9; if applicable		
Federal Tax ID Number (please list all TINs):		
Group/Facility NPI:		
Individual NPI:		
Medicare Certification Number:		
Primary Address:		
City	State:	Zip:
Primary Office Email (provide an email that is not likely to change and can be used for general information and updates):		Primary Office Phone:
Primary Office Fax:	Website:	
SECTION 3: SERVICES PROVIDED		
Type of Practice: Group ☐ Individual ☐ Group/Multi-Specialty ☐ Hospital-Based ☐ Facility ☐ Ancillary ☐ Other ☐ If "Other," please specify:		
Type of Service: Family Practice ☐ General Practice ☐ Specialist ☐ Specify Specialty Acute Hospital ☐ Long-Term Acute Care Facility ☐ Skilled Nursing Facility ☐ Birthing Facility ☐ Ambulatory Surgery Center ☐ Home Health ☐ Hospice ☐ Home Infusion Therapy ☐ Durable Medical Equipment ☐ Prosthetics & Orthotics ☐ Ground Transportation ☐ Other Transportation ☐ Physical Therapy ☐ Chiropractor ☐ Acupuncture ☐ Laboratory ☐ Sleep Center ☐ Specialty Pharmacy ☐ Radiology/Diagnostic Imaging ☐ Behavioral Health ☐ Behavioral Health Prescriber ☐ Behavioral Health Inpatient Facility ☐ Behavioral Health Partial Hospital Facility ☐ Behavioral Health Intensive Outpatient ☐ Behavioral Health Rehab Facility ☐ Applied Behavior Analysis (ABA) ☐ **All behavioral health providers, please complete supplemental questionnaire on page 3.** Other (please be specific):		
Accreditations:		
Licenses Held:		
Hospital Admitting Privileges? Yes ☐ No ☐ If yes, list location(s):		

SECTION 4: ADDITIONAL INFORMATION							
Electronic Filing Capabilities? Yes ☐ No ☐				Do you see patients in your home? Yes ☐ No ☐			
Do you see patients off-site? Yes ☐ No ☐ If yes, check all that apply: Patient's Home ☐ Nursing Facility ☐ Hospital ☐ Other ☐ Please specify location:							
Languages Spoken:							
Do you offer telemedicine services? Yes ☐ No ☐				Are you accepting new referrals? Yes ☐ No ☐			
Office Hours:	Monday:	Tuesday:	Wednesday:	Thursday:	Friday:	Saturday:	Sunday:

BEHAVIORAL THERAPY SPECIALTIES: CHECK ALL THAT APPLY (PLEASE TYPE AN "X" IN THE BOXES BELOW THAT APPLY TO YOU)						
THERAPY	**ALL AGES**	**YOUNG CHILDREN (AGES 1-5)**	**CHILDREN (AGES 6-11)**	**ADOLESCENT (AGES 12-17)**	**ADULTS (AGES 18-64)**	**SENIORS (AGE 65 & OVER)**
ALCOHOL/SUBSTANCE ABUSE	☐	☐	☐	☐	☐	☐
DEMENTIA / AGING / END OF LIFE ISSUES	☐	☐	☐	☐	☐	☐
ANXIETY	☐	☐	☐	☐	☐	☐
ANGER MANAGEMENT	☐	☐	☐	☐	☐	☐
ATTACHMENT DISORDERS	☐	☐	☐	☐	☐	☐
AUTISM SPECTRUM DISORDER/ASPERGERS	☐	☐	☐	☐	☐	☐
BEHAVIORAL & OPPOSITIONAL BEHAVIOR PROBLEMS	☐	☐	☐	☐	☐	☐
BIPOLAR DISORDER	☐	☐	☐	☐	☐	☐
BORDERLINE PERSONALITY DISORDER	☐	☐	☐	☐	☐	☐
CHILDREN'S PLAY THERAPY	☐	☐	☐	☐	☐	☐
SPIRITUAL COUNSELING	☐	☐	☐	☐	☐	☐
COMPUSLIVE GAMBLING	☐	☐	☐	☐	☐	☐
COUPLES/MARITAL/DIVORCE THERAPY	☐	☐	☐	☐	☐	☐
CULTURAL/ETHNIC ISSUES	☐	☐	☐	☐	☐	☐
DEPRESSION	☐	☐	☐	☐	☐	☐
DIALECTIC BEHAVIOR THERAPY	☐	☐	☐	☐	☐	☐
DIVORCE/BLENDED FAMILY/ADOPTION	☐	☐	☐	☐	☐	☐
DOMESTIC VIOLENCE & OTHER ABUSE	☐	☐	☐	☐	☐	☐
DUAL DIGNOSIS (BEHAVIOR & SA)	☐	☐	☐	☐	☐	☐
EATING DISORDERS	☐	☐	☐	☐	☐	☐
EMDR	☐	☐	☐	☐	☐	☐
FAMILY THERAPY	☐	☐	☐	☐	☐	☐
LBGTQ COUNSELING	☐	☐	☐	☐	☐	☐
GRIEF/BEREAVEMENT	☐	☐	☐	☐	☐	☐
HYPNOTHERAPY	☐	☐	☐	☐	☐	☐
MEDICAL ILLNESS/DISEASE / PAIN MGMT	☐	☐	☐	☐	☐	☐
MEN'S ISSUES	☐	☐	☐	☐	☐	☐
MILITARY/VETERANS ISSUES	☐	☐	☐	☐	☐	☐
MOTIVATIONAL INTERVIEWING	☐	☐	☐	☐	☐	☐
NATIVE AMERICAN COUNSELING	☐	☐	☐	☐	☐	☐
OBSESSIVE COMPULSIVE DISORDERS	☐	☐	☐	☐	☐	☐
PANIC/PHOBIA DISORDERS	☐	☐	☐	☐	☐	☐
PERSONALITY DISORDERS	☐	☐	☐	☐	☐	☐
POSTPARTUM & REPORDUCTION ISSUES	☐	☐	☐	☐	☐	☐
POST-TRAUMATIC STRESS DISORDER	☐	☐	☐	☐	☐	☐
PSYCHIATRIC MEDICATION PRESCRIBING	☐	☐	☐	☐	☐	☐
PSYCHOLOGICAL TESTING/ASSESSMENT	☐	☐	☐	☐	☐	☐
SCHIZOPHRENIA/PSYCHOTIC DISORDERS	☐	☐	☐	☐	☐	☐
SEXUAL DYSFUNCTION	☐	☐	☐	☐	☐	☐
WOMEN'S ISSUES	☐	☐	☐	☐	☐	☐
OTHER:	☐	☐	☐	☐	☐	☐