



Volunteer Provider Enrollment

I want to help Cape Fear HealthNet bridge the gap for the low income uninsured.

I will participate by: (check all that apply)

Seeing qualified Cape Fear HealthNet members in my office.

Is the maximum number of referrals I can accept in a month.

Seeing patients at a free clinic.

Helping Cape Fear HealthNet recruit providers.

Name:

Practice Name:

Practice Street Address:

City, State, Zip Code:

Practice Mailing Address:

City, State, Zip Code:

Practice Phone:

Fax:

Contact Person Name:

Contact Person Phone:

Email:

I prefer to receive referrals by:

Email

Fax

Phone

NC Medical License #:

Sub-Specialty(s):

Signature:

Date:
